

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

PATIENT NAME \_\_\_\_\_  
(LAST) (FIRST) (MI)

DATE OF BIRTH \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

**I hereby authorize Glens Falls Hospital (GFH) to:**

Use and/or disclose my protected health information (PHI) to the following organization, agency or individual:

- |   |  |
|---|--|
| <input type="checkbox"/> Doctor's Office                                      | Intended use of the information: _____ |
| <input type="checkbox"/> Other hospital/health facility                       |  |
| <input type="checkbox"/> Insurance Company                                    | _____                                  |
| <input type="checkbox"/> Self/Personal Use                                    |  |
| <input type="checkbox"/> Lawyer   |  |
| <input type="checkbox"/> Family member – Specify by Name & Relationship _____ |  |
| <input type="checkbox"/> Other _____  |  |

Address to mail information (if applicable): \_\_\_\_\_

The medical condition and/or dates of treatment (PHI) should include:

*Expiration:* This authorization shall be in force **1 year from today unless otherwise specified.**

*Revocation:* I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Glens Falls Hospital. I understand that a revocation is not effective to the extent that GFH has relied on the use or disclosure of the PHI.

*Redisclosure:* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*Effect of Not Authorizing:* GFH will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

*Patient Rights:* I understand that I have the right to: Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law if it provides greater access rights) or refuse to sign this authorization.

*Behavioral Health* The Mental Hygiene Law 33.13 governs the confidentiality of clinical behavioral health records. If the above PHI is related to behavioral health treatment, I authorize the use and/or disclosure of my behavioral health PHI.

\_\_\_\_\_  
Signature of Patient or Personal Representative (state relationship and authority)

\_\_\_\_\_  
Date