

**TULLY HILL TREATMENT & RECOVERY  
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL  
HEALTH INFORMATION**

PATIENT LABEL

*I authorize Tully Hill Treatment & Recovery, P.O. Box 1116, Tully, NY 13159 [phone number: (800) 456-6114 fax number: (315)696-8509 email: medrefax@tullyhill.com] and only the following recipient to communicate with and disclose to one another my health information, including information about substance use disorder and mental health/co-occurring disorders.*

**I authorize disclosure to:**

**Person/Organization:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Full Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

Yes No **I consent to disclosure of my HIV-related information.**

**I authorize disclosure of the following information: (Initial next to the items to be released)**

\_\_\_\_\_ The fact that I'm here, how I'm doing and if I've been discharged  
\_\_\_\_\_ Medical records (minimum necessary for my care)  
\_\_\_\_\_ Other (specify): \_\_\_\_\_

**The purpose of this disclosure is for/to: (Initial next to the items that pertain):**

\_\_\_\_\_ Continuity of Care  
\_\_\_\_\_ Keep Significant Others Involved Informed  
\_\_\_\_\_ Keep Employer/School Involved  
\_\_\_\_\_ Insurance/Disability/Legal Issues  
\_\_\_\_\_ Update Medical Records  
\_\_\_\_\_ Other \_\_\_\_\_

**The method of disclosure** may include telephone contact, mail, fax and hand delivery, unless there is a clearly written restriction here: \_\_\_\_\_

**This consent shall automatically expire 12 months after my discharge** from Tully Hill, unless I specify a different time period, event, or condition here (in which case such shall apply to the expiration of this authorization). Alternate time period, event, or condition: \_\_\_\_\_

**All items on this form have been completed and my questions about this form have been answered. I have been provided a copy of this form if I so requested. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to Tully Hill or notifying a staff member.**

\_\_\_\_\_  
Patient's Signature Date: \_\_\_\_\_

\_\_\_\_\_  
Witness's Signature (parent/legal guardian signature if patient is an unemancipated minor) Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Date of Birth

This disclosure is subject to state and federal laws and regulations, including, but not limited to, NYS Public Health Law Section 17, 18 and 27, 42 CFR and 45 CFR. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Disclaimer: The federal E-SIGN Act provides that any law with a requirement for a signature may be satisfied by an electronic signature. Electronic signatures are legally binding in New York State under the Electronic Signatures and Records Act and have the same legal validity as handwritten signatures.