

**EMERGENCY ONE**  
**Urgent Care and Diagnostic Center**  
**40 Hurley Avenue Suite 4**  
**Kingston, NY 12401**  
**845-338-5600**  
**4250 Albany Post Road**  
**Hyde Park, NY 12538**  
**845-229-2602**

**Authorization for Use and Disclosure of Private Health Information**

This form provides authorization to Emergency One to use or disclose certain items of your personal health information for the purpose(s) described below. It is intended to properly inform you of how information will be used or disclosed. You should carefully read the information on this form before signing it.

Patient Name: \_\_\_\_\_ ID# \_\_\_\_\_

1. Who will be disclosing the information? Name of person or entity, or category of persons/entities authorized to make the requested use or disclosure:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Who will be receiving or using the information? Name of person or entity, or category of person/entities, to whom the use or disclosure may be made:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What information will be used or disclosed? The following is a specific description of the information to be used or disclosed, including, but not limited to, the date(s) of service, the type of service provided, level of detail to be released, origin of information, etc.:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What is the purpose of the use or disclosure? This information is being used or disclosed for the specific purpose(s) listed below. If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the

purpose, we will state “at the request of the individual.”

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5. When will this authorization expire? This authorization will be in force and effective until the following date, at which time this authorization expires:

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I understand I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Office Manager at Emergency One, 40 Hurley Avenue, Suite 4, Kingston, NY 12401.

I understand that a revocation is not effective to the extent that Emergency One has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that Emergency One will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences to me of refusing to sign this authorization.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient if the recipient is not required by law to protect the privacy of the information.

I understand that I will receive a copy of this authorization, if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative’s Authority