

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME

BLAYK, BONZE ANNE ROSE
05/01/56 95770

MAIDEN OR OTHER NAME

DATE OF BIRTH

MO DAY YR

CORD #:

ADDRESS:

STATE: ZIP:

DAY PHONE:

I HEREBY AUTHORIZE PP OF

USE

TO OBTAIN

MY HEALTH INFORMATION

NAME:

self

ADDRESS:

PHONE:

Mail results
to pt when
available

STATE:

ZIP:

I specifically authorize release of the

ED:

DATES



Most recent annual exam



All visits since: (fill in date)



Pap Smear



Lab reports



Progress notes



Abortion Record



Follow Up Care related to Medical Abortion of



Follow Up Care related to Surgical Abortion of



Other:



Entire Medical Record

(Fee of \$.50/page. Please allow 10 days. We cannot refuse to give you a copy due to inability to pay)

09/21/12

PURPOSE OF RELEASE OF INFORMATION:



At my request



Continuity of care



Other:

To ensure that our records are current and accurate, please complete & return this form promptly to the clinic site checked below. This will enable us to provide our client with proper medical care. Thank you for your cooperation.

☐ Corning

☐ Elmira

☐ Hornell

☒ Ithaca

☐ Watkins Glen

135 Walnut St.

755 E. Church St.

174 Main St.

314 W. State St.

106 W. 4th St.

(607)962-4686

(607)734-3313

(607)324-1124

(607)273-1513

(607)535-0030

(607)962-7520 fax

(607)734-3392 fax

(607)324-2666 fax

(607)273-8776 fax

(607)535-5040 fax

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on (insert date or event):
2. I may revoke this Authorization at any time by notifying PP of the Southern Finger Lakes in writing, and it will be effective on the date notified except to the extent that PP of the Southern Finger Lakes has already acted upon such Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
5. I have been offered a copy of this signed Authorization form.

SIGNATURE OF PATIENT

DATE

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON

DATE

WITNESS

DATE

AUTHORITY TO ACT ON BEHALF OF PATIENT

DATE REQUEST FILLED:

9-26-12

FOR OFFICE USE ONLY

BY:

IDENTIFICATION PRESENTED:

FORM OF IDENTIFICATION:



Center For Disease Detection
 11603 Crosswinds Way, Ste 100 San Antonio, Tx 78233
 Phone: 888-858-8663 Website: www.cddmedical.com
 CLIA#: 45D0660475

14121
 PP OF THE SOUTHERN FINGER LAKES, INC.
 ITHACA CENTER
 314 WEST STATE ST.
 ITHACA, NY 14850

PATIENT INFORMATION

NAME: BLAYK, BONZE ANNE ROSE
 PATIENT ID#: 95770
 ACCESSION #: 014121031432
 DOB: 05/01/56

SPECIMEN INFORMATION

COLLECTED: 09/21/12
 RECEIVED: 09/24/12
 REPORTED: 09/24/12
 COLLECTED BY: LEIA RAPHAELIDIS
 PERFORMING LAB: CDD

9/25

TEST PERFORMED	IN RANGE	OUT OF RANGE	REF. RANGE
Syphilis	Negative by EIA		NON-REACTIVE
Amplified CT - Urine	Negative		NEGATIVE
Amplified GC - Urine	Negative		NEGATIVE

Comment: Positive nucleic acid amplification test (NAAT) results are considered presumptive evidence of infection. Clinical correlation is necessary to determine if a positive test result is actually due to infection (true positive result), as this likelihood is decreased in low risk asymptomatic patients. A negative result does not preclude infection since results are dependent on specimen adequacy, absence of interfering substances, and a detectable number of organisms.

The analytical performance characteristics of this assay have been determined by CENTER FOR DISEASE DETECTION.
 METHODOLOGY: Strand Displacement Amplification (SDA).

This information has been disclosed to you from confidential records which are protected by law. Privacy laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or otherwise permitted by law. Any unauthorized further disclosure in violation of the law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not, except in limited circumstances set forth in this part, sufficient authorization for further disclosure.

<input type="checkbox"/> Corning 135 Walnut St. (607)962-4686 (607)962-7520 fax	<input type="checkbox"/> Elmira 755 E. Church St. (607)734-3313 (607)734-3392 fax	<input type="checkbox"/> Hornell 111 Seneca St. (607)324-1124 (607)324-2666 fax	<input type="checkbox"/> Ithaca 314 W. State St. (607)273-1513 (607)273-8776 fax	<input type="checkbox"/> Watkins Glen 106 W. 4 th St. (607)535-0030 (607)535-5040 fax
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Rapid HIV Antibody Test Result

Patient Name: Bouze Anne Rose Blayk **Collection Date:** 9/21/12

Counselor Initials: SB

Patient's Date of Birth: / / **Race:** W **Gender:** ~~M~~ F

Name of Authorizing Physician: Joyce Leslie, MD

The HIV-1/2 antibody result from the **Rapid HIV Antibody Test** is:

Non-Reactive
(Negative)



Reactive
(Preliminary Positive)



Invalid



Type of Specimen: ☒ Rapid Test, oral fluid ☐ Rapid test, finger stick with whole blood

Meaning of the test result:

A **non-reactive (negative)** test result means that no antibodies to HIV-1/2 have been detected. HIV antibodies may be absent during the "window period" of infection. Follow-up testing may be necessary if indicated by risk factors.

A **reactive (preliminary positive)** test result suggests that antibodies to HIV-1/2 may be present in the oral fluid or blood. A specimen will have to be sent to a laboratory for a Western Blot test prior to confirmation of the reactive test result. Precautions should be taken to avoid the chance of spreading HIV.

An **invalid** test result resulting from a rapid test can be due to a problem running the test or an interfering substance in the specimen. A specimen using other testing technology should be collected and submitted to a laboratory for HIV testing.

Questions: If you have any questions about the rapid test result, please contact the Authorizing Physician.

Confidentiality and Disclosure:

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.