

A Member of Cayuga Health System 101 Dates Drive Ithaca, NY 14850 (607)274-4011

Designated Caregiver Information



A00082793308 BLAYK, BONZE ANNE ROSE Clifford Ehmke MD F 60

DOB 05/01/1956

Consent To Release Medical Information to Designated Caregiver

I hereby designate the individual listed below as my primary caregiver in accordance with Article 29-CCCC of the Public Health Law (the CARE Act). I consent to Cayuga Medical Center to disclosing medical information regarding my care and treatment to my designated caregiver for purposes of discharge planning and post-discharge care information and instruction. I may change my designated caregiver at any time by notifying a member of my treatment team.

I understand that designating a caregiver and consenting to the disclosure of medical information to my caregiver is voluntary and that I can revoke the designation or consent to share information with my designated caregiver at any time by notifying a member of my treatment team.

Caregiver Name	Caregiver Phone #
lationship to Patient Spouse	Caregiver Address
Patient or Legal Guardian Signature	Date/Time Pt. declind. 17 2/105co.t
Caregiver Designation Change	
I hereby elect to remove the caregiver listed belo designate a new caregiver by filling out a separat Name of caregiver being removed	e consent.
Patient or Legal Guardian Signature	Date/Time



Patient Name		ate of Birth	Patient Identification Number	led Information
BLAYK, BONZE ANNE ROSE		No. Of Diffe	adone identification (vuinter	
Patient Address 05/01/1956 60	597460 ————————————————————————————————————			
Ehmke Cliffond Dans				
I, or my authorized representative, request that health informati		d treatment be released as	set forth on this form. I understand that:	
This authorization may include disclosure of information relating				AL
HIV/AIDS-RELATED INFORMATION only if I place my initia				
information, and I initial the line on the box in Item 8, I specifical	ally authorize release of su	ch information to the person	(s) indicated in Item 6.	
2. With some exceptions, health information once disclosed may be	AL 0 10 TATE OF	one to an use Moreover	N 1 12 10 10 10 10 10 10 10 10 10 10 10 10 10	S 15.5
health treatment information, the recipient is prohibited from re- permitted to do so under federal or state law. If I experience disci	ar as well as the second	and The state of the state of		
Division of Human Rights at 1-888-392-3644. This agency is res			ALDS-related information, I may contact the N	ew Tork State
I have the right to revoke this authorization at any time by writing already been taken based on this authorization.	g to the provider listed bel	ow in Item 5, I understand th	hat I may revoke this authorization except to the	e extent that action has
4. Signing this authorization is voluntary. I understand that generall	0. 2	5 3		l upon my
authorization of this disclosure. However, I do understand that I	may be denied treatment in	n some circumstances if I do	not sign this consent.	
5. Name and Address of Provider or Entity to Relea	se this Information:			
Tompkins County Mental Health Clinic, 20	1 E. Green St., I	thaca, NY 14850	(ph:607-274-6200; f:	607-274-6224)
6. Name and Address of Person(s) to Whom this Inf	formation Will Be D	isclosed:		
Common Medical Common 101 Data Disco	M. NIV 1405		/ 1 /07 274 4204 64	(07.074.4120)
Cayuga Medical Center, 101 Dates Drive, 17. Purpose for Release of Information:	itnaca, NY 14850)	(ph:607-274-4304; f:0	507-274-4130)
	ween parties to c	oordinate treatmer	nt and discharge planning.	
8. Unless previously revoked by me, the specific information by All health information (written and oral), except:	below may be disclosed f	rom: 02/0 Insert star	NT DATE until 02/0	OQ//& ITION DATE OR EVENT
For the following to be included, indicate the specific information to be disclosed and initial below.		Information to	b be Disclosed	Initials
Records from alcohol/drug treatment programs				
☐ Clinical records from mental health programs*			itial assessment, progress notes, n, and treatment status/updates.	BARB
☐ HIV/AIDS-related Information				
9. If not the patient, name of person signing form:		10. Authority to sig	gn on behalf of patient:	
All items on this form have been completed, my question	one about this form ha	ve been answered and I	have been provided a conv of the form	
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED		ve been answered and i	have been provided a copy of the form	02/09/17
Witness Statement/Signature: I have witnessed the	execution of this au	thorization and state th	hat a copy of the signed authorization	ı was
provided to the patient a				1 1
// 1		~		0 2 10 0 111
STAFF PERSON'S NAME AND TITLE	SI LMIY	GNATURE A	75	02/04/1+

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Patient Name BLAYK, BONZE A0008279330	08 MOC		Date of Birth	Patient Identification	n Number
Patient Address 05/01/1956 Ehmke, Cliff	60	F 202-01			
I, or my authorized representative, request the	nat health informat	ion regarding my ca	re and treatment he rele	ased as set forth on this form. I un	derstand that
This authorization may include disclosure of					
HIV/AIDS-RELATED INFORMATION on					
information, and I initial the line on the box i					VI
2. With some exceptions, health information on	ce disclosed may be	e re-disclosed by the r	ecipient. If I am authoriz	ng the release of HIV/AIDS-related	, alcohol or drug treatment, or mental
health treatment information, the recipient is					
permitted to do so under federal or state law.	Total Control of the			of HIV/AIDS-related information, I	may contact the New York State
Division of Human Rights at 1-888-392-3644					
I have the right to revoke this authorization a already been taken based on this authorization		g to the provider liste	d below in item 5. I unde	rstand that I may revoke this authori	zation except to the extent that action has
4. Signing this authorization is voluntary. I under	erstand that general	ly my treatment, payn	nent, enrollment in a heal	th plan, or eligibility for benefits wil	I not be conditional upon my
authorization of this disclosure. However, I d	io understand that I	may be denied treatm	ent in some circumstance	s if I do not sign this consent.	
5. Name and Address of Provider or	Entity to Palar	na thia Informati	one		
3. Name and Address of Flovider of	Entity to Kelea	ise uns imorman	on.		
Cayuga Medical Center, 101 I	Dates Drive.	Ithaca, NY 14	850	(ph:607-2	74-4304; f:607-274-4130)
6. Name and Address of Person(s) to				(pittoon a	11 130 1, 11001 27 1 1130)
*					
Tompkins County Mental Hea		01 E. Green S	t., Ithaca, NY 14	850 (ph:607-2	274-6200; f:607-274-6224)
7. Purpose for Release of Information	n: n choring bot	waan nautias t	a acondinate two	tmont and dischause n	launina
Information	i sharing bet	ween parties t	o coordinate tre	atment and discharge p	ianning.
8. Unless previously revoked by me, the spe		pelow may be disclo	sed from:	RT START DATE unti	II 02 109 16 INSERT EXPIRATION/DATE OF EVENT
For the following to be included, indicate information to be disclosed and ini			Informa	tion to be Disclosed	Initials
Records from alcohol/drug treatm	ent programs				
☐ Clinical records from mental heal	th programs*		evaluation, Histork and status of in	ry & Physical, psychosoc patient treatment.	cial, progress
☐ HIV/AIDS-related Informatio	'n				
9. If not the patient, name of person si	gning form:		10. Authority	to sign on behalf of patient	:
All items on this form have been compl	eted, my questic	ons about this form	n have been answered	I and I have been provided a c	copy of the form.
SIGNATURE OF PATIENT OR REPRESENTA	Mank				02/09/17
Witness Statement/Signature: I hav			s authorization and 's authorized repres		d authorization was
STAFF PERSON'S NAME AND TITLE	Bliss	14/4/4	SIGNATURE	RS.	02/09/17
This form may be used in place of DOH-2557 at	nd has been approxim	d by the NVS Office	of Montal Hoolth and NY	'S Office of Alcoholism and Substan	no. Abuse Services to permit release of

health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related

information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)

Patient Identification Number

A00082793308 M000597460 05/01/1956 60 F		
F		
EDMKA Cliff-		
I, or my authorized representative, request that health informati	on regarding my care and treatment be released as set forth	on this form, I understand that
1. This authorization may include disclosure of information relating		
HIV/AIDS-RELATED INFORMATION only if I place my initia		
information, and I initial the line on the box in Item 8, I specifica		
2. With some exceptions, health information once disclosed may be	re-disclosed by the recipient. If I am authorizing the release of I	HV/AIDS-related, alcohol or drug treatment, or mental
health treatment information, the recipient is prohibited from re-c	fisclosing such information or using the disclosed information for	er any other purpose without my authorization unless
permitted to do so under federal or state law. If I experience discr		ated information, I may contact the New York State
Division of Human Rights at 1-888-392-3644. This agency is res		
 I have the right to revoke this authorization at any time by writing already been taken based on this authorization. 		
4. Signing this authorization is voluntary. I understand that generally		
authorization of this di. closure. However, I do understand that I i	may be denied treatment in some circumstances if I do not sign the	his consent.
5. Name and Address of Provider or Entity to Release	se this Information:	
Cayuga Medical Center 101 Dates Drive I	those NV 14850	(-L.(07.274.4204.6(07.274.4120)
Cayuga Medical Center, 101 Dates Drive, I 6. Name and Address of Person(s) to Whom this Inf		(ph:607-274-4304; f:607-274-4130)
· ·		
7. Purpose for Release of Information:	esty Mentel Health - 201 E. G	rein St. Imaca NY 14850
7. Purpose for Release of Information:		
Information sharing bety	ween parties to coordinate treatment and	discharge planning.
		. / / . 7
Inless previously revoked by me, the specific information b	elow may be disclosed from: 2(1)17	until 6/1/17
	INSERT START DATE	INSERT EXPIRATION DATE OR EVENT
All health information (written and oral), except:		
For the following to be included, indicate the specific		
		product that is about the land of the
information to be disclosed and initial below.	Information to be Disc	
	Pu from date 12	
information to be disclosed and initial below.	All from date 12	L(1/16 BARB
Records from alcohol/drug treatment programs	Summary of treatment, initial assessment, p	L(1/16 BARB rogress notes, treatment
Records from alcohol/drug treatment programs Clinical records from mental health programs*	All from date 12	L(1/16 BARB rogress notes, treatment
Records from alcohol/drug treatment programs	Summary of treatment, initial assessment, p	L(1/16 BARB rogress notes, treatment
Records from alcohol/drug treatment programs Clinical records from mental health programs*	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge	rogress notes, treatment e plan. BARB
Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. stand the patient, name of person signing form:	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from Act 12) (16	rogress notes, treatment e plan. BARB
Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from Act 12) (16	rogress notes, treatment e plan. BARB
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Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. Stand the patient, name of person signing form: Bonce Anne Cose Blank All items on this form have been completed, my question	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from Acte 12) [[[6] 10. Authority to sign on bell parter t ns about this form have been answered and I have be	rogress notes, treatment e plan. X BARB half of patient:
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Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. House Anne Lose Blank All items on this form have been completed, my question SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED I	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from Act 2) [[6] 10. Authority to sign on bell parter t Ins about this form have been answered and I have bell BY LAW execution of this authorization and state that a cop	rogress notes, treatment e plan. X BARB half of patient: en provided a copy of the form.
Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. House Anne Lose Blank All items on this form have been completed, my question SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED I	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from date 2) [[6] 10. Authority to sign on below about this form have been answered and I have been a	rogress notes, treatment e plan. X BARB half of patient: en provided a copy of the form. 2/1/17 by of the signed authorization was
Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. House Anne Lose Blank All items on this form have been completed, my question SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED I	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge Au from Act 2) [[6] 10. Authority to sign on bell parter t Ins about this form have been answered and I have bell BY LAW execution of this authorization and state that a cop	rogress notes, treatment e plan. X BARB half of patient: en provided a copy of the form. 2/1/17 by of the signed authorization was
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Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. Stand the putient, name of person signing form: Bonce Anne Lose Blank All items on this form have been completed, my question SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED I Witness Statement/Signature: I have witnessed the provided to the patient and standard to the patient and standard to the provided to the patient and the information. However, this form does not require health care.	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge for from date 2) [[[6]] 10. Authority to sign on below this form have been answered and I have been answe	rogress notes, treatment e plan. X BARB Malf of patient: en provided a copy of the form. 2/1/7 by of the signed authorization was Yard points and Substance Abuse Services to permit release of
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Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information 9. Stand the patient, name of person signing form: Bone Anne Lose Blank All items on this form have been completed, my question SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED I Witness Statement/Signature: I have witnessed the provided to the patient and standard of the patient and standard of the provided to the patient and the information. However, this form does not require health care.	Summary of treatment, initial assessment, p plan, treatment status/updates, and discharge for from date 2) [[[G]] 10. Authority to sign on below the patient's authorization and state that a copy of the patient's authorized representative. All of the patient's authorized representative. SIGNATURE If by the NYS Office of Mental Health and NYS Office of Alcohoroviders to release health information. Alcohol/drug treatment-required statements regarding prohibition of re-disclosure.	rogress notes, treatment e plan. X BARB Malf of patient: en provided a copy of the form. 2/1/17 by of the signed authorization was Yours notism and Substance Abuse Services to permit release of related information or confidential HIV-related

Date of Birth

Authorization for Release of Health Information (Including Alcohol/Drug Treatment

Pa	BLAYK, BONZE ANNE ROSE MO0082793308 MO00597460	Date of Birth	Patient Identification Number
Pa	A00082793308 M000597460 05/01/1956 60 F Ehmke,Clifford BSU 202-01		

- types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
- 2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon

5. Name and Address of Provider or Entity to Release this Information: Nick Berg Tampkins County Mental Health - 201 E. Green St., 1. 6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:	Oraca NY 4850
	Mara NY 4850
	inala NT PISO
Canaga Medical Center, 101 Dates Drive, Hnaca, NY 14837. Purpose for Release of Information:	50
7. Purpose for Release of Information:	
Information Sharing between parties	11.11
Information Sharing between partice 8. Unless previously revoked by me, the specific information below may be disclosed from: INSERT START DATE Until INSERT START DATE Until UNIVERSE University Uni	SERT EXPIRATION DATE OR EVEN
All health information (written and oral), except:	
Washington Salata Salata Salata Salata Washington St. Salata Kasa	
For the following to be included, indicate the specific information to be disclosed and initial below.	Initials
information to be disclosed and initial below. Information to be Disclosed	
M Records from alcohol/drug treatment programs Au from Start date	BARB
	BARB
Clinical records from mental health programs* All from Start date HIV/AIDS-related Information All from Start date	BARB
9. If not the patient, name of person signing form: 10. Authority to sign on behalf of patient:	
Il items on this form have been completed, my questions about this form have been answered and I have been prov	ided a copy of the form.
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW	2/1/17
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW	DATE
Vitness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the	e signed
authorization was provided to the patient and/or the patient's authorized representative	ve.
STAFF PERSON'S NAME AND PITLE SIGNATURE	
STAFF PERSON'S NAME AND PITLE SIGNATURE	DATE
his form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and S primit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treat onfidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-dis	tment-related information or

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for

the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

	nd Mental Health		NAME OF TAXABLE PARTY.	
Pa BLAYK, BONZE ANNE BOCE	Dat	e of Birth	Patient Identification	Number
A00082793308 M000597460				
Pi Fhmko Cliff	· ·			
Emike, Clifford BSU 202-01			The state of the s	
or my authorized representative, request that health information	on regarding my care and	treatment be relea	sed as set forth on this form. I und	erstand that:
This authorization may include disclosure of information relating	to ALCOHOL and DRUG	TREATMENT, MI	ENTAL HEALTH TREATMENT, an	d CONFIDENTIAL
HIV/AIDS-RELATED INFORMATION only if I place my initia	A THE RESERVE THE PROPERTY OF			ow includes any of these types of
information, and I initial the line on the box in Item 8, I specifical	A STATE OF THE STA			
 With some exceptions, health information once disclosed may be health treatment information, the recipient is prohibited from re-d 			Tarre 100 100 100 100 100	and the same of the same of
permitted to do so under federal or state law. If I experience discr				
Division of Human Rights at 1-888-392-3644. This agency is resp				
. I have the right to revoke this authorization at any time by writing already been taken based on this authorization.	to the provider listed below	w in Item 5. I under	stand that I may revoke this authorize	tion except to the extent that action
. Signing this authorization is voluntary. I understand that generally				not be conditional upon my
authorization of this disclosure. However, I do understand that I n	nay be denied treatment in	some circumstances	if I do not sign this consent,	
5. Name and Address of Provider or Entity to Releas	se this Information:			
Samuel Medical Control 101 Data District	.1 307.14050		(b. (07.07	14 4204, £607 274 41°
Cayuga Medical Center, 101 Dates Drive, I 6. Name and Address of Person(s) to Whom this Info			(pn:607-27	'4-4304; f:607-274-413
Nick Perm	ormation will be Dis	sciosed.		
7 Promote Pales (1)				
7. Purpose for Release of Information. Information sharing bety	ween parties to co	ordinate trea	tment and discharge pla	nning. 10G
				DIA /
All health information (written and oral), except:		INSE	f start date	INSERT EXPIRATION DATE OR EVI
For the following to be included, indicate the specific information to be disclosed and initial below.		Informa	ion to be Disclosed	Initials
Records from alcohol/drug treatment programs			e de la companya del companya de la companya del companya de la co	
Clinical records from mental health programs*	ALL			BARF
☐ HIV/AIDS-related Information				
9. If not the patient, name of person signing form:		10. Authority	to sign on behalf of patient:	
Ill items on this form have been completed, my question	as about this form how	a baan angwarad	and I have been provided a co	ny of the form
All items on this form have been completed, my question	ns about this form hav	e been answered	and I have been provided a co	py of the form.
Some Stark		e been answered	and I have been provided a co	py of the form.
All items on this form have been completed, my question Me OGUE SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED E		e been answered	and I have been provided a co	py of the form. A 12311
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED E	BY LAW execution of this auth	norization and s	tate that a copy of the signed	4/23/1'
Witness Statement/Signature: I have witnessed the	execution of this author/or the patient's auth	norization and s	tate that a copy of the signed	4/23/1'
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED E Witness Statement/Signature: I have witnessed the provided to the patient ar STAFF PERSON'S NAME AND TITLE	execution of this author/or the patient's author/or the patient author/or	norization and sthorized representation	tate that a copy of the signed ntative.	authorization was
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED E Witness Statement/Signature: I have witnessed the provided to the patient ar	execution of this author/or the patient's author/or the providers to release health	norization and sthorized representations	tate that a copy of the signed intative. S Office of Alcoholism and Substance Udrug treatment-related information	authorization was

Authorization for Release of Health Information (Including Alcohol/Drug Treatment

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY	xecution of this authorization and state that a copy of the sign/or the patient's authorized representative.	gned authorization was
60170 Dorest	LAW	1/3/(
	s about this form have been answered and I have been provided	a copy of the form.
. If not the patient, name of person signing form:	10. Authority to sign on behalf of patie	ent:
☐ HIV/AIDS-related Information		
Clinical records from mental health programs*	ALL	BAPB
Records from alcohol/drug treatment programs		
For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
Unless previously revoked by me, the specific information be All health information (written and oral), except:	ow may be disclosed from: 123(7 u	intil Z/28/7 INSERT EXPIRATION DATE OR EVE
ayuga Medical Center, 101 Dates Drive, It Purpose for Release of Information: Information sharing betw	een parties to coordinate treatment and discharge	7-274-4304; f:607-274-413 planning.
Name and Address of Person(s) to Whom this info	wation Will De Disclosed.	
. Name and Address of Provider or Entity to Release	this Information:	STORE AND STORE ST
	by be denied treatment in some circumstances if I do not sign this consent.	and the contained apon my
already been taken based on this authorization.	my treatment, payment, enrollment in a health plan, or eligibility for benefits	
Division of Human Rights at 1-888-392-3644. This agency is resp. I have the right to revoke this authorization at any time by writing	onsible for protecting my rights. o the provider listed below in Item 5. I understand that I may revoke this auth	horization except to the extent that action
	closing such information or using the disclosed information for any other pur mination because of the release or disclosure of H1V/AIDS-related information	
With some exceptions, health information once disclosed may be r	e-disclosed by the recipient, If I am authorizing the release of HIV/AIDS-rela	
HIV/AIDS-RELATED INFORMATION only if I place my initial:	on the appropriate line in item 8. In the event the health information describe authorize release of such information to the person(s) indicated in Item 6.	
	ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMEN	
	n regarding my care and treatment be released as set forth on this form. I	Lunderstand that
ntie 05/01/1956 60 F Ehmke,Clifford BSU 202-01		
	Date of Birth Patient Identifica	adon Numba
atic BLAYK, BONZE ANNE ROSE A00082793308 M000597460		ation Number

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.