Hometown Health Centers

1044 State Street, Schenectady, New York 12307
Tel: (518) 370-1441
67 Division Street, Amsterdam New York 12010
Tel: (518) 627-2110
www.hometownhealthcenters.org

Consent to Disclose Personal Health Information

I, _____, **authorize** _____
(Print your name) *(Print name of health information custodian)*

to disclose ☐ my personal health information consisting of:

_____

_____
(Describe the personal health information to be disclosed)

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of: _____

_____
(Describe the personal health information to be disclosed)

to _____
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Patient Name: _____

Address: _____

Contact Telephone #: _____

Signature: _____ **Date:** _____

Witness Name: _____

Address: _____

Telephone #: _____

Signature: _____ **Date:** _____

***Please note: A substitute decision-maker is a person authorized under HIPAA to consent, on behalf of an individual, to disclose personal health information about the individual.**