



Mental health records Communicable Diseases (including HIV and AIDS)

Alcohol/drug abuse treatment Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative:

Printed name of patient or personal representative and his or her relationship to patient:

Date:

/ /

Mail the form and documents to: AgeWell New York
1991 Marcus Avenue- Suite M201 Lake
Success, NY 11042

1.866.237.3210 | agewellnewyork.com

Law firms, record retrieval agencies, and third party insurance entities requesting a claims payment report for litigation or subrogation purposes, please note: you must submit a notarized authorization to receive records.