ROCHESTER REGIONAL HEALTH

United Memorial Medical Center
127 North Street Batavia NY 14020

MR No.:_____
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AUTHORIZATION FOR DISCLOCURE OF MEDICAL RECORD INFORMATION (PATIENT/FAMILY ACCESS TO MEDICAL RECORDS)

Patient Name:_____ **Birthdate:**_____

Address:_____ **Phone #** _____

I, the undersigned patient or legal representative, hereby authorize UNITED MEMORIAL MEDICAL CENTER to provide:

_____
Identity of patient or name of qualified representative

with access to my medical/hospital records for the purpose of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

I understand that I may be charged a fee for copies.

***** NEVER TO BE USED FOR VERBAL DISCLOSURE OF PATIENT CONDITION INFORMATION**

Type of Treatment: Inpatient Outpatient

The foregoing is subject to such limitations as indicated below:

( ) 1. Confined to records regarding admission and treatment for the following medical conditions or injury:
on or about _____.
Date

( ) 2. Covering records for the period from _____ to _____.

( ) 3. Confined to the following specified information:
_____.

( ) 4. No limitation placed on dated, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and/or drug abuse. (Signer must initial for authentication of this response.)
_____

_____ Expiration date of this
PHYSICIAN APPROVED authorization, if any: _____

_____ _____
PHYSICIAN DENIED Signature of Patient or Relation

Date Patient Contacted: _____ _____ **Date Signed**

If signed by the Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:
*☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Health Care Proxy ☐ Other*_____