

MR No.: _____
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Initials: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION ***

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize:

Name: _____

Address: _____

to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information regarding:

Patient Name: _____ **Birthdate:** _____

The information may be disclosed to and used by the following:

Name: _____

Address: _____

Phone # _____ Fax # _____

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

The dates of service and the type(s) of information to be used or disclosed are as follows:

Discharge Date: _____

Dates:

- | | | |
|---|---|-------|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Reports | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultations | _____ |
| <input type="checkbox"/> ED Record | <input type="checkbox"/> Progress Notes | _____ |
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Radiology Reports | _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Laboratory Reports | _____ |
| _____ | <input type="checkbox"/> Pathology Reports | _____ |
| | <input type="checkbox"/> Radiology Films | _____ |

The purpose of this disclosure or use is for the following reason:

- Medical Legal Disability Insurance At the request of the patient
 Other _____

This authorization will be valid for a period of six months from the date below. I understand that I may revoke this authorization at any time by notifying Medical Records in writing, but if I choose to revoke this authorization, it will not have any effect on actions that the hospital took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or continued treatment by the health care provider is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Signature of Patient or Legal Representative

Date

Witness

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 _____

HIV RELATED INFORMATION

In the event that information release constitutes confidential HIV related information protected under New York Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

If the event that information release constitutes confidential psychiatric information protected under New York Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.