MVHS
St. Elizabeth
Medical Center
Utica, NY

Patient Sticker Or	MR#:
	Acct#:

Authorization to Release / Obtain Protected Health Information

Patient Name: ______________________ Date Of Birth: ____________

Address: ______________________ Phone Number: ____________
Street City Zip

Internal Use Only: ☐ Pick Up ☐ Mail ☐ FOC (proof obtained) ☐ Request to Physician ☐ Extended Release ☐ See Distributee Form

1) I authorize St. Elizabeth ______________________
(Medical Center / Medical Group Site)

☐ **TO RELEASE this patient's information to**	☐ **TO OBTAIN this patient's information from** ☐ Patient Being Seen Right Now ➡ Fax records to # ________ ➡ To the Attention of: ________

Name:	
Address:	
City/State/Zip Code	
(Area Code) Phone:	(Area Code) Fax Number:

2) Description of information that may be disclosed (check off the appropriate items):

(Date(s) of Service)
____
____
____

☐ Abstract of Hospital Record (ED/dictations/tests/discharge)
☐ History & Physical / Discharge Summary
☐ Emergency Dept. Record
☐ Other (please describe) ______________________
☐ Entire Medical Record
☐ Labs / Radiology
☐ Immunization Records

* **Specific authorization is required to release the following documentation. If authorizing release, please check and initial**

☐ _____ Substance Abuse Records (initial) ☐ _____ Psychiatric Records (initial) *HIV (requires separate NYS release form, please ask for assistance)

3) The information will be used/disclosed for the following purposes:

☐ Continuity/Transfer of Care ☐ Legal ☐ Disability
☐ Insurance/Payment of Bills ☐ Other ______________________

4) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information authorized for disclosure in item number two (2) above may be re-disclosed and may be no longer protected by these regulations.

5) I understand that by authorizing St. Elizabeth Medical Center, to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photo copies of my records.

6) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may also request to inspect my records.

7) I understand that I may revoke this authorization in writing at any time by completing the bottom of this form or by contacting the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. This authorization expires on: ______________________ (insert applicable date or event), or within 1 year of the date of the authorization, whichever is greater.

Date: ________ **Time:** ________ **Signature of Patient/Legal Representative:** ______________________

If Legal Representative, relationship to patient: ______________________

***I am revoking this authorization and no longer authorize records to be released as of the date below.**

Date: ________ **Time:** ________ **Signature of Patient/Legal Representative:** ______________________

Date: ________ **Time:** ________ **Witness Signature:** ______________________