St. Elizabeth Medical Center
Utica, NY

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Authorization to Release/Obtain Protected Health Information

Patient Name: _____ Date Of Birth: _____

Address: _____

Phone Number: _____ Medical Record Number: _____

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

☐ **TO RELEASE the above named individual's health information to**	☐ **TO OBTAIN the above named individual's health information from** ☐ Patient Being Seen Right Now (Unit_____)

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

1) Description of information that may be disclosed (check off the appropriate items): _____
(Date(s) of Service)

☐ Abstract of Hospital Record
☐ Emergency Room Record
☐ Radiology (X-Ray) Results
☐ History & Physical
☐ Laboratory Results
☐ Entire Medical Record
☐ Other (please describe) _____

***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)

2) The information will be used/disclosed for the following purposes:
☐ Continuity/Transfer of Care
☐ Disability
☐ Other _____
☐ Legal
☐ Insurance/Payment of Bills

3) 1 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 one (1) above may be re-disclosed and may be no longer protected by these regulations.

4) 1 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.

5) 1 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 inspect or request a copy of any information disclosed under this authorization, per the Medical Center's ''Request for Access to Medical Records'' policy.

6) 1 understand that I may revoke this authorization in writing at any time 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 six (6) months or the date of the authorization, whichever is greater.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
If signed by Legal Representative, relationship to patient