VASSAR BROTHERS MEDICAL CENTER

HEALTH INFORMATION MANAGEMENT DEPARTMENT
1 Columbia Street, Suite 101, Poughkeepsie, NY 12601 845-437-3020

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

THERE MAY BE REPRODUCTION AND POSTAGE FEES ASSOCIATED WITH THIS REQUEST

PATIENT NAME:____
Last First

ADDRESS: ____
Street City State Zip

DATE OF BIRTH: ______________________ **PHONE NUMBER:** ______________________________

I hereby authorize **Vassar Brothers Medical Center** to **RELEASE** my protected health information to:

NAME: ____________________________________ **PHONE NUMBER:** ________________________

ADDRESS: ____
Street City State Zip

I hereby authorize Vassar Brothers Medical Center to **RECEIVE** my protected health information from:

NAME: ____________________________________ PHONE NUMBER: ________________________

ADDRESS: ____
Street City State Zip

Information Requested:

- ❑ ER Records ❑ Abstract ❑ Discharge Summary ❑ Operative/ Pathology Report
- ❑ Labs ❑ Radiology ❑ History & Physical ❑ Complete Record
- ❑ Other: ____

Approximate Date(s) of Treatment: ____

Include: (Initial) ____ Alcohol/Drug Treatment; ____ Mental Health Information; ____ HIV-Related Information

Reason for release of information: __At Request of Individual; __Continuation of Medical Care; __Other ________________

This Authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or government agency specified below:

By initialing here ______ I authorize ______________________________________ to discuss my health information
Initials Name of individual health care provider

with my attorney, or governmental agency, listed here: ____
Attorney/Firm Name or Governmental Agency Name

In accordance with New York State and Federal Laws, I understand that: This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line. In the event the health information described above includes any of these types of information, and I initial the line, I specifically authorize release of such information to the person(s) indicated herein. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. I have the right to revoke this authorization at any time by writing to the health care provider listed herein. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above), and this re-disclosure may no longer be protected by federal or state law. All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE:____

PLEASE PRINT NAME CLEARLY:____

AUTHORITY TO SIGN ON BEHALF OF PATIENT:__________________________ **DATE:**____________________

DATE/EVENT THAT THIS AUTHORIZATION WILL EXPIRE: ___________________________

(*If expiration date left blank, this authorization will expire in six (6) months from the date of this request*). 1-15-15