Nuvance Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

There may be reproduction and postage fees associated with this request

Please indicate what hospital(s) you are requesting records from:

☐ Vassar Brothers Medical Center
T: 845-437-3020; F: 845-437-3155

☐ Northern Dutchess Hospital
T: 845-871-3300; F: 845-871-3590

☐ Putnam Hospital
T: 845-279-5711; F: 845-278-5642

☐ Sharon Hospital
T: 860-364-4057; F: 860-364-4188

Patient Name: _____Date of Birth: _____

Address: _____

Med Rec Number: _____ Phone Number: _____

Persons/Organization receiving the information:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____
(For Medical Facilities Only)

Purpose/Reason (please indicate): _____

Information to Be Released:

- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Radiology Reports
- ❑ ER Records
- ❑ Pathology Report
- ❑ Abstract of Records
- ❑ Operative/Procedure Report
- ❑ Labs
- ❑ Complete visit(s)
- ❑ Other: _____

Approximate Date(s) of Treatment: _____

Initial to Release: _____ Alcohol/Drug Treatment _____Mental Health Information ____HIV Information

Format you would like records in: _____ Paper _____ CD _____ Other (please indicate)

In accordance with 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. 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.

Signature of patient / authorized representative: _____

Print Name : _____

Date/event that this authorization will expire: _____ Date Signed:_____

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

If not the patient, name of person signing form:	**Authority to sign on behalf of patient:**