**AUTHORIZATION FOR RELEASE OF INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **AOMC Form 8710.48H** | **SJH Form 642.23H (6/12)** |  |  |
| **Persons/organizations providing the information:** | |  |  |
| **o St. Josephs’ Hospital** | **o Arnot Ogden Medical Center** | **o Ira Davenport Memorial Hospital** | **o AMS Offices** |
| **555 St. Joseph’s Blvd.** | **600 Roe Ave.** | **7571 State Route 54** | **600 Ivy St., Ste 102** |
| **Elmira, NY 14901** | **Elmira, NY 14905** | **Bath, NY 14810** | **Elmira, NY 14902** |
| **Phone: 607-733-6541** | **Phone: 607-737-4302** | **Phone: 607-776-8727** | **Phone: 607-737-4500** |
| **Fax: 607-737-7018** | **Fax: 607-737-4403** | **Fax: 607-776-8623** | **Fax: 607-737-7700** |

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** Iunderstand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form.

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| --- | --- |
|  |  |
| **Patient Name:** | **Date of Birth:** |
| **Patient Address:** | **Patient Phone:** |
|  | **o Check box if we cannot leave a voicemail** |
|  |  |
| **Persons/organizations receiving the information:** |  |

|  |  |  |  |  |  |
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| **Specific description of information (including dates)** | | | |  |  |
| **o** | Abstract (all dictated notes, face | **o** | Discharge Summary | **o** Radiology Records | |
|  | sheets, labs, X-rays, EKGs) | **o** | Entire Emergency Record | **o** | Labs |
| **o** History & Physical | | **o** | Operative Note | **o** | Physical Therapy |
| **o** | Consultation | **o** | Pathology Records | **o** | Hand Management |
| **o** | Discharge Instructions | **o** | Anesthesia Record | **o** | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Dates of Treatment:**

1. What is the purpose of the request?
2. I understand that this authorization will expire on \_\_\_/\_\_\_/\_\_\_ or upon compliance with the request for information, whichever occurs first. **Initials**:

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it

won’t have any affect on any actions they took before they received the revocation. **Initials**:

|  |  |
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| **Drug, Alcohol, HIV and Psychiatric Exclusion** |  |
| o Check this box ONLY if you do not consent to the release of drug, alcohol, HIV and/or psychiatric information. | |
| \*\* This form is not valid for records pertaining to the Behavioral Science Unit, STARS Program and New Dawn Program. | |
| Please contact facility where treatment occurred. | **Initials:** |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature** | **Date** |

Relationship, if not patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Witness** |  |  | **Date** |  |  |  |
|  | |  | | |  | |
| To be Completed by Arnot Health Staff: | | Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Initials: \_\_\_\_\_\_\_\_\_ | |
| MR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Number of Pages Delivered: \_\_\_\_\_\_\_\_\_ | | | **o** Mailed | **o** Faxed | **o** Hand Delivered |