



Patient Sticker Or	MR#:
	Acct#:

**Authorization to Release / Obtain
Protected Health Information**

Patient Name: _____

Date Of Birth: _____

Address: _____
Street City Zip

Phone Number: _____

1) I authorize Faxton St. Luke's _____
(Healthcare / Medical Group Site)

Internal Use Only:	
<input type="checkbox"/> FOC (proof obtained)	<input type="checkbox"/> Pick Up <input type="checkbox"/> Mail
<input type="checkbox"/> Extended Release	<input type="checkbox"/> Request to Physician
	<input type="checkbox"/> See Distributee Form

<input type="checkbox"/> TO RELEASE this patient's information to	<input type="checkbox"/> TO OBTAIN this patient's information from
	<input type="checkbox"/> 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) Entire Medical Record

_____ History & Physical / Discharge Summary Labs / Radiology

_____ Emergency Dept. Record Immunization Records

_____ Other (please describe) _____

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

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

(initial) (initial)

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 Faxton St. Luke's Healthcare, 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: _____