AUBURN COMMUNITY HOSPITAL
Health Information Management
ATTN: Release of Information
Phone: (315) – 255-7322
Fax: (315) – 255-7092

Auth:_____
Patient ID: _____
For Office Use Only

RELEASE OF INFORMATION AUTHORIZATION

17 Lansing St
Auburn, NY 13021

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. 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 lines. In the event the health information described below includes any of these types of information, and if I initial the appropriate line, I specifically authorize release of such information to the person(s) indicated. **2.** 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. **3.** I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. **4**. 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. **5.** Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. Requests for medical records are subject to reproduction fees in accordance with Federal and State regulations.

Patient Name:_____Date of Birth:_____/_____/_____
Address: _____
City:_____State:_____ZIP: _____
E-mail Address:_____ Phone: _____

I request that my protected health information [PHI] from Auburn Community Hospital be disclosed to:
Recipient Name: _____
Address: _____
City:_____State:_____ZIP: _____
E-mail Address:_____ Phone: _____
Fax [**Healthcare Provider Only**]: _____

I authorize the following PHI to be released from my medical record[s]: Emergency Room Record Laboratory Report[s] Radiology Report[s] Pathology Report Immunization Record
Abstract/Summary [Includes Discharge Summary, History & Physical, Operative Report[s], Consultations, and Test Results]
Test Result[s] of: _____
Radiology film/imaging studies/tracing/media
Itemized Billing Records
Other:
_____

3ROI

I understand that the information in my health record may include information relating to sexually transmitted disease [STD], acquired immunodeficiency syndrome [AIDS], or human immunodeficiency virus [HIV]. It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained [include dates where appropriate]:

Alcohol, drug, or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health	☐ Yes	☐ No	Dates: _____
Psychotherapy Records	☐ Yes	☐ No	Dates: _____

Covering the period of healthcare from: Specific Date[s]: _____ to _____ **OR**
All past, present, and future encounters/visits.

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other [*please specify on the line below]:*

_____

By signing this authorization form, I understand that:

- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire **1 year** from the date signed.

_____ _____

Signature Date

FEE WAIVER: ☐ Social Security Benefits ☐ Veterans Benefits ☐ Disability-Based Medicaid

☐ Other Government Benefits ☐ Other _____