

# VASSAR BROTHERS MEDICAL CENTER

45 Reade Place, 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:

- |                                       |                                    |   |  |
|---------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> ER Records   | <input type="checkbox"/> Abstract  | <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Operative/ Pathology Report |
| <input type="checkbox"/> Labs         | <input type="checkbox"/> Radiology | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Complete Record             |
| <input type="checkbox"/> 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).