Cayuga
MEDICAL CENTER
A Member of Cayuga Health System

Office Use Only:
MR # _____
Acct. # _____

ID Checked: ☐ Yes ☐ No
If No checked, why: _____

# Authorization for Release of Information

**When requesting health information records, please be very specific to ensure you receive all the information you require. Also, please be advised that Health Information Management will process fully completed Authorization forms as required by federal law (HIPAA). Incomplete Authorizations will be returned to sender with explanation as to what is missing.**

**FEES: Health records will be sent to another healthcare provider free of charge as a professional courtesy. All other requests are subject to fees of $.75 per page. Health records are released upon payment of all fees.**

I hereby authorize Cayuga Medical Center to release copies of my medical records as directed below to:
(please enter complete mailing address)

_____
_____
_____

**DESCRIPTION OF INFORMATION:**

Patient Name: _____ Date of Birth: _____

Dates of Service: _____ Date Needed By: _____
(Normal Processing Time if No Date)

**INFORMATION TO BE RELEASED:**

☐ History & Physical
☐ Discharge Summary
☐ Consultation
☐ EKG
☐ Occupational/PT
☐ ER/Convenient Care
☐ Laboratory Results/Pathology
☐ X-ray Reports
☐ Operative Report
☐ Record Abstract
☐ Accounting of Disclosure
☐ Billing Communication

**Includes: (Indicate by Initialing)**
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV/STI-Related Information

☐ Other: _____

**REASON FOR RELEASE:**

☐ At request of individual ☐ Other: _____

I understand I may revoke this authorization at any time by presenting written revocation to the Health Information Management Department. Revocation will not apply to information already released in response to this authorization. I understand that any release of information carries with it the potential for redisclosure by the recipient and may not be protected by the federal privacy rules. Cayuga Medical Center will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date or event) _____.
If I fail to specify an expiration date or event, this authorization will expire after 6 months. The patient may request a copy of this authorization.

_____ _____
(Signature of patient or legal representative) (Date) (Must be entered or request will be returned)

_____ _____
(Relationship, if other than patient) (Date)

_____
(Address of Patient/Legal Representative/Family Relationship)

*****Please scan completed form and email to: medicalrecords@cayugamed.org**
**or send completed form to the Health Information Department at the address below*****


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