

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

AUTHORIZATION FOR RELEASE OF INFORMATION

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: _____
Dates of Service: _____
Date Needed By: _____

Date of Birth: _____

INFORMATION TO BE RELEASED:

- | | |
|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Results/Pathology |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Record Abstract |
| <input type="checkbox"/> Occupational/PT | <input type="checkbox"/> Accounting of Disclosure |
| <input type="checkbox"/> ER/Convenient Care | <input type="checkbox"/> Billing Communication |
| <input type="checkbox"/> Other: _____ | |

Includes: (Indicate by Initialing)

- _____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV/STI-Related Information

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)

(Address)

(Relationship, if other than patient)

(Address)

(Completed by)

(Date)

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 Authorization will be returned to sender with explanation as to what was 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.

*****Please send completed form to Health Information Department*****

