

Elizabethtown Community Hospital
 75 Park Street
 Elizabethtown, NY 12932

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. **BY SIGNING THIS FORM, YOU AUTHORIZE THE SPECIFIED UNIVERSITY OF VERMONT HEALTH NETWORK ENTITY TO RELEASE INFORMATION TO THE PARTIES LISTED ON PAGE TWO (2) OF THIS DOCUMENT.**
2. **PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY THE RELEASE.**

I understand and agree that:

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management by **Phone: (518) 873-3065 or Fax: (518) 873-3067.**
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the Entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at the hospitals, home health, and hospice agencies within The University of Vermont Health Network.
- **This authorization will expire on _____ . If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.**

When a patient is a minor*, or is not competent to give authorization, the signature of parent, guardian or other legal representative is required. Supporting documentation of the legal representative should be provided with this form.**

Signature of Patient/Legal Representative	Date	Time
Print Name	Relationship to Patient (if signed by Legal Representative)	

Section A

Patient Name: _____ Date of Birth: _____ Phone Number: _____
 Patient Address: _____ City: _____ State & Zip Code: _____

Section B: Release of Information:

<input type="checkbox"/> Medical Care	<input type="checkbox"/> Personal Records	<input type="checkbox"/> Insurance/ Payment	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Other:
<input type="checkbox"/> Attorney/Legal Proceedings	<input type="checkbox"/> Provider Transfer	<input type="checkbox"/> Disability	<input type="checkbox"/> School	

Section C: Recipient of information:

- Release a copy of my protected health information (PHI) to me.
 Release/disclose my PHI to: Receive information from:

Name:	
Address:	
Phone Number:	Fax Number:
Method of Disclosure: <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Electronic	

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Section D: Description of the Information to be released:

The date of service and type(s) of information to be used or disclosed are as follows:

Date of Service or Date Range: _____ to _____

Hospital Record			Physician Office Records	
<input type="checkbox"/> Hospital Abstract (includes any available documents below OR check only those documents needed)			<input type="checkbox"/> Outpatient Clinic Abstract (includes any available documents below OR check only those documents needed) Clinic/Physician name: _____	
<input type="checkbox"/> Consultation	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Allergy List	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Rehab Services	<input type="checkbox"/> Medication List	<input type="checkbox"/> Problem List
Report: <input type="checkbox"/> Cardiology <input type="checkbox"/> ED <input type="checkbox"/> EKG <input type="checkbox"/> Pathology <input type="checkbox"/> Operative/Surgical <input type="checkbox"/> Radiology			<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other
<input type="checkbox"/> Radiology Film		<input type="checkbox"/> Other		

Section E

I understand that the information in my health record may include information relating to sexually transmitted disease, treatment for mental health related issues, treatment of alcohol or drug use disorder and genetic testing or screening results.

By **initialing** the box below, I authorize the release of this information to the recipient in Section D (*include dates where appropriate*):

Alcohol, Drug, or Substance Use Treatment Records (records from alcohol/drug treatment programs) *	Initials: _____ Dates: _____
HIV Testing and Results (<i>requires completion of New York State authorization form for New York hospitals/clinics</i>) *	Initials: _____ Dates: _____
Mental Health Visits / Psychotherapy Records**	Initials: _____ Dates: _____
Genetic screening test results	Initials: _____ Dates: _____

* This form does not require health care providers to release health information. Alcohol/drug treatment-related information and confidential HIV/AIDS-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. (42 CFR Part 2; NYS PBH § 2780)

** Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. (NYS MHY § 33.13)

***NYS Pub Health Law § 17 limits disclosure of prenatal care, abortion, venereal disease testing/treatment (or any other treatment that a minor can consent to without parent consent) to parents without patient consent.

For Office Use Only	
I have authenticated the identity of the person named in this authorization form via <input type="checkbox"/> Photo ID <input type="checkbox"/> Other	
Date Received	Date Completed
Employee Signature	

