Samaritan Hospital
Medical Records Phone: 518-271-3671
Medical Records Fax: 518-271-3605

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ _____

Address:_____**City**_____**State**:_____**Zip**:_____

Date of Birth:_____ **Phone No**:_____

Dates of Treatment:_____

Medical Record # (office use): _____**Type of Visit**: ☐Outpatient ☐Emergency ☐Inpatient

Request format: ☐ **Paper** ☐ **Electronic Delivery** ☐ **CD**

Electronic delivery via secure portal link unless other means is specifically requested. Please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft.

DESCRIPTION OF MEDICAL RECORDS REQUESTED

Please select facility from which you are requesting records:

☐ Albany Memorial Hospital
☐ Sunnyview Rehabilitation Hospital
☐ St. Peter's Hospital
☐ Samaritan Hospital
☐ Samaritan Hospital-St. Mary's Campus
☐ Other _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING HEALTH INFORMATION:

❑ Summary or Abstract of Record
❑ Entire Medical Record

Or only the documents indicated below:

❑ Discharge Notes
❑ Admission History & Physical
□ Psychotherapy notes or mental health
❑ Anesthesia Record
❑ Pathology Report
❑ Diagnostic/X-Ray Reports
❑ Laboratory Results
❑ Emergency Room Notes
❑ Medication Record
❑ Radiology Film
❑ Medical Imaging CD
❑ Nurse Notes
❑ Progress Notes
❑ Consults
❑ Physician Orders
□ Other: _____

Please send information to: (Include full name, address, phone number, and email address (for electronic delivery))

_____

_____

_____

Purpose: □ At my request □ Continued Medical Care □ Legal □ Insurance □ Other: _____

If your medical record contains any records obtained from other providers (not applicable to medical imaging), **please check one**:

❑ I prohibit their release □ I authorize and request their release [unless prohibited by the other provider(s)].

This Authorization is valid for up to *12 months from the date of signature*, unless a shorter period is listed below.
Expiration Date or Event:_____

Please see reverse page

I understand that I may refuse to sign this Authorization. If I do not complete this Authorization, it will not affect the use or disclosure of my protected health information (PHI) for purposes of treatment, payment or eligible for benefits. I can change my mind at any time and revoke, in writing, my permission to allow my PHI to be used or disclosed under this Authorization except to the extent St. Peter's Hospital relied on this Authorization.

I understand that St. Peter's Health Partners will not release my PHI to others except as authorized by me or permitted by law. Once my PHI is shared with a group or individual that is not required to follow federal privacy laws, St. Peter's Health Partners cannot assure that the information will remain confidential.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), Genetic Testing, behavioral or mental health services, and/or treatment for alcohol and/or drug abuse.

Initials below authorizes release of all such information,

_____Alcohol/Drug Treatment
_____Behavioral/Mental Health Information
_____Sexually Transmitted Disease
_____HIV/AIDS –Related Information
_____Genetic Testing

Signature of Patient or Legal Representative: **Date:**

_____ _____

Name of Personal Representative (if applicable) (Please print): **Relationship to Patient:**

_____ _____

<u>For release to the patient</u>, there is a fee based on type of delivery (paper vs electronic). Electronic records sent in electronic format (CD or electronic) - $6.50. Paper records are charged based on a per page fee. There is no fee for copies of medical records sent to physicians/health care providers, except for Radiology Film.
Note: St. Peter's Health Partners has contracted with MRO to handle the release of medical record information. 7/2018