

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:

- | | |
|--|--|
| <input type="checkbox"/> Albany Memorial Hospital | <input type="checkbox"/> Samaritan Hospital |
| <input type="checkbox"/> Sunnyview Rehabilitation Hospital | <input type="checkbox"/> Samaritan-St. Mary's Campus |
| <input type="checkbox"/> St. Peter's Hospital | <input type="checkbox"/> Other _____ |

I AUTHORIZE THE RELEASE OF THE FOLLOWING HEALTH INFORMATION:

- | | |
|--|--|
| <input type="checkbox"/> Summary or Abstract of Record | <input type="checkbox"/> Entire Medical Record |
|--|--|

Or only the documents indicated below:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Discharge Notes | <input type="checkbox"/> Anesthesia Record | <input type="checkbox"/> Emergency Room Notes | <input type="checkbox"/> Nurse Notes |
| <input type="checkbox"/> Admission History & Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychotherapy notes or mental health | <input type="checkbox"/> Diagnostic/X-Ray Reports | <input type="checkbox"/> Radiology Film | <input type="checkbox"/> Consults |
| | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Medical Imaging CD | <input type="checkbox"/> Physician Orders |
| | <input type="checkbox"/> 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: _____

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), 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

Signature of Patient or Legal Representative:

Date:

Name of Personal Representative (if applicable) (Please print):

Relationship to Patient:

For release to the patient, 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