

UNIVERSITY MEDICAL PRACTICE ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

(Use this form to obtain medical information from a Healthcare Provider facility not affiliated with SLRHC)

M.R.# _____

PATIENT NAME _____ DATE OF BIRTH _____ S.S.# _____

STREET, APT # _____

CITY, STATE, ZIP CODE _____ TELEPHONE # _____

1. I hereby authorize _____ TEL # _____ FAX# _____
to release information from my medical record to :

2. NAME _____

3. ADDRESS _____ CITY, STATE, ZIP CODE _____

For the purpose of (please check one)

_____ Continued Treatment _____ Legal Review _____ Insurance purpose
_____ Personal review of information _____ Other (please specify) _____

3. I limit the information to be released to the following items: (Please check specific items)

_____ Discharge Summary _____ Consultation _____ Diagnostic test (e.g. Lab, X-ray, Radiology)
_____ Operative Note _____ Pathology _____ Other (please specify)
_____ Emergency Department Record _____ Out patient Record (please specify)

Covering records from on or about (Date) _____ to (Date) _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:
_____ I understand that if my record contains information concerning mental health and /or drug and alcohol treatment; such information will be release pursuant to this authorization.

_____ I understand that if my record contains confidential HIV related information; such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

5. I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. If I experience discrimination because of release of HIV confidential information, I can call the NYS Division of Human Rights at (212) 480-2493 and/ or the NYC Commission of Human Rights at (212) 306-7450.

6. This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at St. Luke's- Roosevelt Hospital Center. I understand the revocation will not apply to information that has already been released in response to this authorization.

7. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

8. I also understand that in an effort to prevent unauthorized re-disclosure St. Luke's - Roosevelt Hospital Center attaches a notice when sending out records that states, " re-disclosure is prohibited." However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

9. I also understand that in order to process this request to reproduce medical record information on a timely basis, University Medical Practice Associates, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release information to such photocopy service for the purpose of satisfying this request.

(Signature of Patient/Representative/ or Legal Guardian)

(Date)

(If other than patient, relationship to patient)

(Notary/Witness)