VASSAR BROTHERS MEDICAL CENTER

45 Reade Place Poughkeepsie, NY 12601
845-437-3020

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or authorized representative and returned.

THERE MAY BE A PROCESSING FEE ASSOCIATED WITH THIS REQUEST

STEP 1: INFORMATION ABOUT THE PATIENT: Please Print Clearly

PATIENT NAME:_____
Last First

ADDRESS:_____
Street City State Zip

DATE OF BIRTH:_____ **PHONE NUMBER:**_____

STEP 2: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS TO?

I, or my authorized representative, hereby authorize **Vassar Brothers Medical Center** to release my protected health information to:

NAME:_____ **PHONE NUMBER:**_____

ADDRESS:_____
Street City State Zip

STEP 3: TO RELEASE THE FOLLOWING INFORMATION- PLEASE SPECIFY:

DATES:_____**TO**_____

☐ ER Records ☐ Abstract ☐ Discharge Summary ☐ Operative/ Pathology Report
☐ Labs ☐ Radiology ☐ History & Physical ☐ All Permitted Medical Records
☐ Other:_____

Include: (Indicate by Initialing)

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

Reason for release of information:

☐ Continuation of Medical Care
☐ Processing of a Claim
☐ Other:_____

STEP 4: YOUR SIGNATURE:

In accordance with New York State and Federal Laws, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Step 3. In the event the health information described above includes any of these types of information, and I initial the line on the box in Step 3, I specifically authorize release of such information to the person(s) indicated herein.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
4. I have the right to revoke this authorization at any time by writing to the health care provider listed herein. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
6. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above), and this redisclosure may no longer be protected by federal or state law.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE:_____

PLEASE PRINT NAME CLEARLY:_____

AUTHORITY TO SIGN ON BEHALF OF PATIENT:_____**DATE:**_____

DATE/EVENT THAT THIS AUTHORIZATION WILL EXPIRE: _____
(*If expiration date left blank, this authorization will expire in six (6) months from the date of this request*).

PLEASE USE REVERSE SIDE TO REQUEST RECORDS FROM ANOTHER HEALTHCARE FACILITY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or authorized representative and returned.

STEP 1: INFORMATION ABOUT THE PATIENT: Please Print Clearly

PATIENTNAME:_____
Last First

ADDRESS:_____
Street City State Zip

DATE OF BIRTH:_____ **PHONE NUMBER:**_____

STEP 2: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS TO?

I, or my authorized representative, hereby authorize:

NAME:_____ **PHONE:**_____

ADDRESS:_____
Street City State Zip

to release my protected health information to:

Vassar Brothers Medical Center 45 Reade Place Poughkeepsie, NY 12601

STEP 3: TO RELEASE THE FOLLOWING INFORMATION- PLEASE SPECIFY:

DATES:_____**TO**_____

□ ER Records □ Abstract □ Discharge Summary □ Operative/ Pathology Report
□ Labs □ Radiology □ History & Physical □ All Records
□ Other:_____

Include: (Indicate by Initialing)

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

Reason for release of information:

□ Continuation of Medical Care
□ Processing of a Claim
□ Other:_____

STEP 4: YOUR SIGNATURE:

In accordance with New York State and Federal Laws, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Step 3. In the event the health information described above includes any of these types of information, and I initial the line on the box in Step 3, I specifically authorize release of such information to the person(s) indicated herein.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
4. I have the right to revoke this authorization at any time by writing to the health care provider listed herein. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
6. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above), and this redisclosure may no longer be protected by federal or state law.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE:_____

PLEASE PRINT NAME CLEARLY:_____

AUTHORITY TO SIGN ON BEHALF OF PATIENT:_____**DATE:**_____

DATE/EVENT THAT THIS AUTHORIZATION WILL EXPIRE: _____
(*If expiration date left blank, this authorization will expire in six (6) months from the date of this request*).

PLEASE USE REVERSE SIDE TO REQUEST RECORDS FROM VASSAR BROTHERS MEDICAL CENTER