

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.

	TION ABOUT THE PATIEN		Please Print Clearly			
PATIENT NAME:						
	Last	First				
ADDRESS:Stro	<u> </u>	City St	tate Zip			
Suv		City	2.10			
DATE OF BIRTH:	P.	HONE NUMBER:				
	DO YOU WISH TO RELE					
	entative, hereby authorize Vassar B	Brothers Medical Center to	release my protected health			
information to: NAME:						
ADDRESS:	Street City	State	Zip			
STEP 3: TO RELEAS!	E THE FOLLOWING INFO					
SIEI 3. TO RELEASI	e THE FOLLOWING INFO	JKMATION-TEEAS	ESIECHI.			
DATES:	ТО					
□ ER Records □ Abstra	ct Discharge Summary	☐ Operative/ Patholo	gy Report			
☐ Labs ☐ Radiol	ogy   History & Physical	☐ All Permitted Medi	cal Records			
☐ Other:						
Include: (Indicate by In		Reason for release of				
Alcohol/Drug Treats		☐ Continuation of Medical	Care			
Mental Health Infor		□ Processing of a Claim				
HIV-Related Inform	ation	Utilet.				
This authorization may include dispsychotherapy notes, and CONFII health information described above information to the person(s) indicated and the person of the person of the such information without my authorized and the person of the such information without my authorized and person of the such information without my authorized or use my HIV-related.  If I experience discrimination becardary of the New York of the Albardary of the New York of the Albardary of the Except to the extent that action has the such that action has the person of the such that action of this disc.  Information disclosed under this are federal or state law.  All items on this form have been complete.	te and Federal Laws, I understand that: closure of information relating to ALCOHO DENTIAL HIV RELATED INFORMATION e includes any of these types of information, ted herein.  IIV-related, alcohol or drug treatment, or me orization unless permitted to do so under fed d information without authorization. use of the release or disclosure of HIV-related. City Commission of Human Rights at (212) corization at any time by writing to the health already been taken based on this authorization is voluntary. My treatment, payme losure.	Nonly if I place my initials on the a and I initial the line on the box in ental health treatment information, eral or state law. I understand that ed information, I may contact the 1306-7450. These agencies are resperted to a care provider listed herein. I understand that interest is the plant of the provider listed herein. I understand the plant of the prient (except as noted above), and been answered. In addition, I have	appropriate line in Step 3. In the event the Step 3, I specifically authorize release of such the recipient is prohibited from redisclosing I have the right to request a list of people who New York State Division of Human Rights at onsible for protecting my rights. restand that I may revoke this authorization eligibility for benefits will not be conditioned this redisclosure may no longer be protected by been provided a copy of the form.			
PLEASE PRINT NAME CLEARLY:						
AUTHORITY TO SIGN ON I	BEHALF OF PATIENT:	DATI	չ:			
DATE/EVENT THAT THIS A	AUTHORIZATION WILL EXPI	RE:				
(If expiration date left blank, this authorization will expire in six (6) months from the date of this request).						

## **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: INFOR	INFORMATION ABOUT THE PATIENT:			Please Print Clearly				
PATIENTNAME:								
	Last		First					
ADDRESS:	- Ci		3	Ct. d				
	Street	(	City	State	Zip			
DATE OF BIRTH:		PHONE NU	MBER:					
STEP 2: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS TO?								
I, or my authorized repre	esentative, hereby autho	rize:						
NAME:			PHONE:					
ADDRESS:								
	Street	(	City	State	Zip			
to release my protected h								
Vassar Brothers M	edical Center 45 R	eade Place Poughkee	epsie, NY 12601					
STEP 3: TO RELEASE THE FOLLOWING INFORMATION- PLEASE SPECIFY:								
DATES:		то						
DATES:  ☐ ER Records	□ Abstract	☐ Discharge Summary	☐ Operative/ Patholog	gv Report				
$\square$ Labs		☐ History & Physical						
☐ Other: Reason for release of information:								
Alcohol/Dru	Alcohol/Drug Treatment   Continuation of Medical Care							
Mental Heal	th Information		cessing of a Claim					
HIV-Related		□ Oth	er:					
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 fo								
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).								