Cayuga Medical Center

THE CENTER IS YOU

Approved by NYS Department of Health

Office use only:
MR# _____
Acct.# _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Cayuga Medical Center at Ithaca to release copies of my medical records as directed below to: (please enter complete mailing address)

_____

_____

_____

DESCRIPTION OF INFORMATION

Name: _____ Date of Birth: _____

Dates of Service: _____

Date Needed By: _____

INFORMATION TO BE RELEASED

☐ History & Physical ☐ Laboratory Results

☐ Discharge Summary ☐ X-ray reports

☐ Consultation ☐ Operative Report

☐ EKG ☐ Record Abstract

☐ Occupational Health Reports/Results

☐ ER/Convenient Care ☐ Other _____

Includes: (Indicate by initialing)

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

REASON FOR RELEASE:

☐ At request of individual

☐ Other: _____

I understand I may revoke this authorization at any time by presenting written revocation to the Health Information Management Department. Revocation will not apply to information already released in response to this authorization. I understand that any release of information carries with it the potential for re-disclosure by the recipient and may not be protected by the federal privacy rules. Cayuga Medical Center will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date of event) _____. If I fail to specify an expiration date or event, this authorization will expire after 6 months.

_____ _____
(Signature of patient or legal representative) (Address)

_____ _____
(Relationship, if other than patient) (Address)

_____ _____
(Completed by) (Date)

The patient may request a copy of this authorization
Please send completed form to Health Information Department, 101 Dates Drive, Ithaca, NY 14850