Rochester General Hospital

1425 Portland Avenue
Rochester, NY 14621

585-922-4000

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:		**Patient Date of Birth:**	
Patient Address:		**Patient Phone Number:**	
City/State/Zip Code:		**Medical Record Number:**	
Social Security #		**Date of Request:**	

OR

☐ I authorize **Rochester General Hospital** to **release information to:**

Name of Provider or Facility or other recipient

Address

City, State, Zip Code

Phone # / Fax # (include area code)

☐ I authorize **Rochester General Hospital to obtain information from:**

Name of Provider or Facility or other recipient

Address

City, State, Zip Code

Phone # / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (check one) ☐ Healthcare ☐ Insurance coverage ☐ Personal
☐ Other (specify) _____

TYPE OF RECORDS REQUESTED: (check off the appropriate item(s), and include other information, where indicated):
☐ Immunization Record ☐ Procedure report ☐ History & physical ☐ Physical Therapy
☐ All medical records related to a specific illness or injury: _____
Specify illness/injury Date(s) of treatment
☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology reports)
☐ Specific information (Select one or more, as applicable)
☐ Laboratory test results ☐ X-ray reports ☐ Other (please describe) _____

AUTHORIZATION VALID FOR: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form. I understand that the cancellation will not apply to information that has already been released in response to this authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records. ($0.75/page for paper copies)
- Refusal to sign this authorization does not condition (affect) treatment.
- I will be given a copy of this authorization form, after signing.

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient

Signature of Witness Date