



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Place patient identification sticker here

Patient Name:	Date of Birth:	MR#:
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Address:	Phone:
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I hereby authorize: Samaritan Medical Center, 830 Washington Street, Watertown, NY 13601
 Samaritan Keep Nursing Home, 133 Pratt Street, Watertown, NY 13601
 Samaritan Summit Village, 22691 Campus Drive, Watertown, NY 13601
 Samaritan Family Health Center, location
 Other:

to release personal health information from the medical records of the above named patient:
 To:
 Name & Address of Person/Organization to which disclosure is to be made

For the following purpose:
 For the following dates of service (must be completed):

Type of Access Requested		Select Portions Requested	
Copies of record	Entire Record	Labs	MD Progress Notes
View Record Only	Emergency Room Visit	Imaging/Radiology	MD Orders
	History & PhysicalD	Cardiac/EKG	Other:
	Consultations	Discharge Summary	
	Operative/Procedure	Pathology Report Only	

This authorization expires 90 days from the date signed below unless otherwise revoked

I, the undersigned, request that the health information regarding my care and treatment be released as indicated on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, I understand that:

1. I have the right to revoke this authorization at any time (except to the extent that information has already been released based on this authorization) by notifying Samaritan's Health Information Management Department in writing. My written request to revoke this authorization must be signed, dated, and sent to: Samaritan Medical Center, Medical Records, 830 Washington Street, Watertown, New York 13601.
2. 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.
3. Information disclosed by this authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law. I release and discharge this facility of any liability and hold this facility harmless for complying with this request for medical imaging.

 Signature of Patient/Legal Representative

Relationship/Authority

Date

We may impose a reasonable, cost-based fee, in compliance with all laws and regulations applicable to release of information.

Please list method used to verify identity if records are to be hand delivered.

Federal Register, Department of Health & Human Services, 45 CFR, Standards for Privacy of Individually Identifiable Health Information, Section 164.524

