Samaritan Medical Center
Watertown, NY

MySamaritanHealth

AUTHORIZATION FOR PATIENT POWERSHARE ACCESS

Patient Name:	Date of Birth:	MR #:
Address:		Phone:
Email address:		

I hereby authorize: ☐ Samaritan Medical Center, 830 Washington Street, Watertown, NY 13601

to allow access to my personal health information from the medical records of the above named patient:

To: _____
Name & Address of Person to which disclosure is to be made

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 "Authorization for Release of Medical Information".*

_____ _____
Print Name Date

_____ _____
Signature of Patient/Legal Representative Relationship/Authority

Please list method used to verify identity.

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