# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**ATTENTION:** This form is **NOT** valid for the release of specific confidential information, including Alcohol/Drug Treatment, HIV/AIDS and Mental Health Information. See other forms to complete those Release of Information requests.

**Please return completed form to:** Samaritan Medical Center, 830 Washington Street, Watertown, NY 13601 – Attention: Medical Records Department.

**Fax Number:** 315-785-4645
**Phone Number:** 315-785-4198
**Email Address:** him@shsny.com OR radfileroom@shsny.com *(Image Requests only)*

| Patient Last Name: | | Patient First Name: |
|---|---|---|
| Address: | | |
| Date of Birth: | Medical Record Number: | Phone: |

**I hereby authorize** *(please check all that apply)*

- ☐ Samaritan Medical Center
- ☐ Samaritan Family Health Clinics
- ☐ Samaritan Specialty Clinics
- ☐ Samaritan Medical Practice
- ☐ Samaritan Summit Village
- ☐ Samaritan Keep Home
- ☐ Samaritan Home Health
- ☐ Other (please specify): _____

**to disclose a copy of the specific PHI identified below to the following specified person, facility, or entity**:

_____

_____

Name, Address, and Phone Number of Person/Entity to which disclosure will be made. Include Fax Number if records are to be sent via fax. Include email address if records are to be sent via email.

- **for the following purpose** (i.e. continuity of care, litigation needs, personal records, etc.): _____
- **for the following dates of service** (Date(s) of encounter (all visits or can be a range): _____

**Type of Access Requested**:

- ☐ Release Physical Copies of Record by Mail
- ☐ Release Physical Copies of Record for in-person pick-up
- ☐ Release Copies of Record directly to Provider
- ☐ View Record Only
- ☐ Release Copies of Record via unencrypted Email*
- ☐ Release Copies of Record via encrypted Email
- ☐ Release Copies of Record via Fax*

*If you select unencrypted email or fax, these are unsecure methods of transmission. By signing below, you are accepting the risks that the unencrypted email or fax can be accessed, intercepted, and/or further disclosed by an unauthorized third-party. Samaritan Medical Center is not responsible for unauthorized access or disclosure once we send the requested information to who you designate above.

**Portions of Record Requested**:

- ☐ Entire Record (Up to 25 Years)
- ☐ Emergency Room Visit
- ☐ History and Physical Reports
- ☐ Consultation Reports
- ☐ Operative/Procedure Reports
- ☐ Progress Notes
- ☐ Discharge Summary Reports
- ☐ Imaging/Radiology – Images
- ☐ Imaging/Radiology – Reports
- ☐ Pathology – Reports only
- ☐ Cardiac/EKG Studies
- ☐ Labs
- ☐ Billing Information
- ☐ Other _____

**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 the information has already been released based on this authorization) by notifying Samaritan Medical Center's Health Information Management Department in writing. My written request to revoke this authorization must be signed, dated, and sent to Samaritan Medical Center, 830 Washington Street, Watertown, New York 13601, Attention: Medical Records.*
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 Samaritan Medical Center of any liability and hold this facility harmless for complying with this "Authorization for Release of Medical Information."*

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

| Patient/Legal representative signature | Date | Time |
|---|---|---|
| Patient/Legal representative printed name | Relationship | |

*******Staff use only: List method used to verify identity:** _____