Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Authorization for Release of Information

Doc. 106 Rev. 9/28/2021

□Community Memorial Hospital	□ CMH- Family Health CTR	□ CMH-Family Health CTR	□ CMH- Family Health CTR	□ CMH-Family Health CTR
Hamilton, NY 13346	Hamilton, NY 13346	Morrisville, NY 13408	Munnsville, NY 13409	Waterville, NY 13480
Phone 315-824- 6529	**Phone 315-824-4600**	**Phone 315-684-3117**	**Phone 315-495-2690**	**Phone 315-841-4184**
Fax 315-824-6558	**Fax 315-824-8447**	**Fax 315-684-9848**	**Fax 315-495-3915**	**Fax 315-202-4031**

Patient Name Date of Birth Phone Number

Address City, State Zip

Please check one:

Purpose: □ Medical Treatment □ Disability □ Insurance □ Legal Reasons □Personal

Upcoming appointment date: ______________________________ Medical Record Number____________

Name and address of Person/
Institution Releasing information:__________

Name and address of Person/
Institution Receiving Information:________

Extent of Information To Be Released (Including dates, provider ect.)____________________________________

Please do not disclose the following without speaking with your Supervisor: □**HIV-Related Information**

Release Form Valid From________________________to____________________(If blank, 365 days from date of signature)

The releasing provider listed above is hereby authorized to release information from the medical records of the above named patient. This authorization permits release of information to include information such as psychological or psychiatric impairments, drugs use and/or alcoholism, information indicating HIV related test, HIV infection, HIV related illness, AIDS or any information which could indicate potential exposure to HIV and any information related to or regarding genetic testing.

I understand that Community Memorial Hospital will not condition treatment on my providing authorization for disclosure. I further understand that I do not have to allow the release of this information in part or entirety. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Community Memorial Hospital, Privacy Officer, 150 Broad Street, Hamilton, NY 13346. I understand that a revocation will not apply to information that has already been released.

I understand that the information to be released from the medical record is confidential and will not be released except to the person/institution named below. I acknowledge that any disclosure to a third party can lead to unauthorized re-disclosure by that person or others, which may not be subject to federal or state confidentiality laws.

Please select one of the following. I would like my medical records in:

[ ] Paper Format: Please be advised that a fee of $0.75 per page may be charged for all paper medical records copied/printed
[ ] Electronic Format (CD): Medical records can be provided (PDF Format) for a flat rate of $6.50.
[ ] Secure Email: (Subject to a $6.50 flat fee) ______________________________
[ ] Fax number: ______________________________

Please note: All scanned records to any external email address (e.g. gmail, yahoo, etc.) must be encrypted for security purposes. If the email address you provide is an external address, the information you receive will be encrypted. To open the email, you must follow the directions in the registration process. Electronic medical records requested (CD or Email) are only available (if the medical record is dated from 07/01/2010 to present. Records requested that are older than 10 years are subject to retention and destruction policy and procedure.)

______________________________/______________ ______________________

Signature of patient, parent or legal guardian (relationship) Date

___________________________________/________________ ______________________________
Signature of Witness Date Address of Witness

TO BE COMPLETED BY COMMUNITY MEMORIAL HOSPITAL STAFF

RELEASE	**REQUEST**
(To be completed by Medical Records Staff ONLY)	(To be completed by All Staff)
Validation of Requestor's Identity______________	Request sent by______________________________
(Please note what form of ID was presented)	Date_______________
	Department:________________________________
Number of Pages Copied_________Date_________	**Sent via:** □ Fax □ Mail □ Secure Internet File
	□Sent with Patient of Patient Representative
Completed by:_____________________________	Number of pages Copied_________Date__________