United Memorial
Medical Center

Quality care right at home.
127 North Street Batavia NY 14020

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION ***

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize:

Name:____

Address:____

to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information regarding:

Patient Name:_____________________________________ **Birthdate:**____________________

The information may be disclosed to and used by the following:

Name:____

Address:____

Phone # ______________________________ Fax #_________________________________

Method of Disclosure: ☐ Mail ☐ Pick-up ☐ Fax ☐ Review

*** NEVER TO BE USED FOR VERBAL DISCLOSURE OF PATIENT CONDITION INFORMATION

The dates of service and the type(s) of information to be used or disclosed are as follows:
Discharge Date:________________

☐ History and Physical
☐ Discharge Summary
☐ ED Record
☐ Billing Record
☐ Other ______________________
____

Dates:

☐ Operative Reports ______________
☐ Consultations ______________
☐ Progress Notes ______________
☐ Radiology Reports ______________
☐ Laboratory Reports ______________
☐ Pathology Reports ______________
☐ Radiology Films ______________

The purpose of this disclosure or use is for the following reason:
☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ At the request of the patient
☐ Other ______________________

This authorization will be valid for a period of six months from the date below. I understand that I may revoke this authorization at any time by notifying Medical Records in writing, but if I choose to revoke this authorization, it will not have any effect on actions that the hospital took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or continued treatment by the health care provider is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

____ ___________________________________
Signature of Patient or Legal Representative **Date**

____
Witness

If signed by the Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:
☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Health Care Proxy ☐ Other____________

HIV RELATED INFORMATION

In the event that information release constitutes confidential HIV related information protected under New York Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

If the event that information release constitutes confidential psychiatric information protected under New York Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.