



HEALTH INFORMATION DEPARTMENT

- Buffalo Mercy Hospital
565 Abbott Rd. Buffalo NY 14220
716-828-2322
- Sisters of Charity Hospital Main St. Campus
2157 Main St. Buffalo NY 14214
716-862-1986
- Sisters of Charity Hospital St. Joseph Campus
2605 Harlem Rd. Cheektowaga NY 14225
716-891-2157
- Kenmore Mercy Hospital
2950 Elmwood Ave. Kenmore NY 14217
716-447-6116

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please Note:

There is no charge for records being released to a doctor or hospital. All other requests for records will be charged a fee of \$.75 per page copied.

Patient Name: _____ DOB: _____

Patient Address: _____

Telephone: _____ Cell Phone: _____

Date(s) of Treatment: _____ Type(s) of Treatment: _____

This form authorizes the provider to disclose the following specific health information to the recipient named below. Portions of the medical record is available electronically and can be provided to you on a CHS provided USB device for a nominal fee. Paper copies can be picked up in the Health Information Department 8am- 4 pm Monday – Friday or will be mailed to you upon request. Documents will be picked up Please mail the information to me at the address below.

Name/Department: _____ Email: _____

Address: _____ FAX: _____

Information Requested:

- Entire Record Discharge Summary Operative Report Physician's Notes X-Ray Face Sheet History & Physical Pathology Report
- Laboratory Clinical Letter Discharge Instructions Other: _____

This authorization is granted for the following purpose(s): _____

This authorization is valid until ___/___/___ or until the occurrence of the following event: _____

Or in any case not to exceed one year.

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations. **However, in the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies:** THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CRF PART 2) PROHIBIT 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 SUCH REGULATIONS

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I am signing this authorization voluntarily.

Only ONE of the following sections must be completed.

This section is to be completed if authorization is being given by the Individual:

Signature of Individual _____ Date Signed _____

This section is to be completed if authorization is given by a Personal Representative:

Name of Personal Representative: _____ Signature of Personal Representative _____

Date Signed _____ Description of Authority to act as personal Representative of the Individual (e.g., Guardian, Attorney, Health Care Agent) _____

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - Both (non-HIV medical and HIV-related information)
 - My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

Relationship to person whose information will be released: _____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized From: _____ To: _____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

All facilities/persons listed on pages 2, 3 (and 4 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____ Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 2:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 2:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

Complete information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 2:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 2:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 2:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____

Client/Patient Number _____