ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

327 Beach 19th Street, Far Rockaway, NY 11691
718-869-7799

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

I hereby authorize St. John's Episcopal Hospital to take the following action.

ACTION REQUESTED (check one)

❑ Provide a copy of **My Health Information** to me ❑ Let me look at **My Health Information** (I am not requesting a copy)

❑ Release **My Health Information** to: ❑ Discuss **My Health Information** with: ❑ Obtain copies of My **Health Information** from:

_____
(name of other person or entity)

_____ _____
(street address) (city)

_____ _____ _____
(state) (zip code) (fax number)
(we cannot call before faxing)

For this Authorization, **"My Health Information"** means (check one or more)

❑ Abstract (discharge summary, operative notes, clinic notes, diagnostic testing)
❑ Billing Record
❑ Diagnostic test/Results (lab, x-rays and other test results)
❑ Discharge Summary
❑ Emergency Room Record
❑ History & Physical
❑ Immunization Record
❑ Mental Health Records
❑ Operative Report
❑ Outpatient Record
❑ Pathology Report
❑ Progress Report
❑ Other: _____ _____

If I have initialed here (_____), I understand that this information may include HIV/AIDS related information, alcohol/drug treatment, mental health information.

If I have initialed here (_____), this Authorization does NOT include records from other healthcare providers that are a part of my St. John's Episcopal Hospital records included in this request.

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)
(insert date(s)of service requested) (Note: Information from recent visits may not yet appear in the record.)

❑ At my request ❑ For my healthcare/treatment ❑ For legal purposes ❑ For payment/insurance purposes

Other: _____

COPY – MEDICAL RECORDS COPY – PATIENT / REPRESENTATIVE

FORMAT

I request that the copy be provided (where possible/available):
❑ on paper ❑ electronically on CD

Important: I understand that the CD/disc is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. By choosing to receive **My Health Information** on a CD/disc, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____ . I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date:** ____ / ____ / ____

(Required)

If you are NOT the patient but are signing on behalf of the patient, please complete below

I, _____ **am the (check which applies)**

(print your name)

❑ **Parent with Parental Rights** *(not sufficient for substance abuse records)*

❑ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*

❑ **Court Appointed Guardian**

❑ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*

❑ **Medical Power of Attorney** *(not sufficient for substance abuse records)*

❑ **Power of Attorney with Right to See Medical Records** (not sufficient for substance abuse records)

❑ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*

❑ **Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ **Date:** ____ / ____ / ____

(Required)

Address: _____ **Phone:** _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

COPY – MEDICAL RECORDS COPY – PATIENT / REPRESENTATIVE