

**Authorization for Release of Protected Health Information**

**St. Mary's Hospital , Amsterdam**

For St. Mary's Hospital Addiction Services (√) here

**Patient Identification**

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Please check type of Information to be released:**

- |                           |                          |                          |                          |                                   |                          |
|---------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|
| ER Record                 | <input type="checkbox"/> | XRay/Imaging/Film/Report | <input type="checkbox"/> | Presence in Treatment             | <input type="checkbox"/> |
| History and Physical Exam | <input type="checkbox"/> | Progress Notes           | <input type="checkbox"/> | Psychiatric Evaluation            | <input type="checkbox"/> |
| Laboratory test results   | <input type="checkbox"/> | Discharge Summary/Plan   | <input type="checkbox"/> | Progress & Prognosis              | <input type="checkbox"/> |
| Photographs, Videotapes   | <input type="checkbox"/> | Nurses Notes             | <input type="checkbox"/> | Treatment Plan                    | <input type="checkbox"/> |
| Clinical Intake           | <input type="checkbox"/> | Itemized Bill            | <input type="checkbox"/> | ETOH Assess/<br>Psychosocial Eval | <input type="checkbox"/> |

Other, (specify) \_\_\_\_\_

Specify purpose of request \_\_\_\_\_

**Disclose to/Request from – circle one:**

Name of Person			Facility
Address	City	State	Phone Number

**Time Limit and Right to Revoke Authorization**

Except to the extent that action has already been taken on reliance of this authorization. I understand that I have the right to revoke this authorization by submitting a notice in writing to the facility Privacy Officer at St. Mary's Hospital, Medical Record Department, 427 Guy Park Avenue, Amsterdam. Unless revoked, this authorization will expire in 360 days from date of signature.

**Re-disclosure (General)**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and in such cases no longer can be protected by the Health Insurance Portability and Accountability Act of 1996. In such cases, the facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Redisclosure (Behavioral Health: Addiction and Mental Health)**

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 this information to criminally investigate or prosecute any **alcohol** or drug abuse patient.

**Signature of Patient or Personal Representative Who May Request Disclosure**

I understand that this authorization has nothing to do with my treatment or payment. It is strictly for the release of my protected health information. I have the right to inspect or have copied the protected health information to be used or disclosed. A copying fee will be incurred for some requests. I authorize St. Mary's Hospital to use and disclose the protected health information specified above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient, relationship to patient: \_\_\_\_\_

Identity of Requestor Verified via: **Photo ID** \_\_\_ **Matching Signature** \_\_\_ **Other, Specify** \_\_\_\_\_

Verified by: \_\_\_\_\_