Authorization for Release of Protected Health Information

St. Mary's Healthcare

427 Guy Park Avenue, Amsterdam, NY 12010

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

Patient Identification

Printed Name:______________________ Date of Birth:______________

Social Security# XXX-XX-__________

Address:______________________ Telephone:______________

Please check type of Information to be released:

ER Record	☐	X Ray/Imaging/Film/Report	☐	Presence in Treatment	☐
History and Physical Exam	☐	Progress Notes	☐	Psychiatric Evaluation	☐
Laboratory test results	☐	Discharge Summary/Plan	☐	Progress & Prognosis	☐
Photographs, Videotapes	☐	Nurses Notes	☐	Treatment Plan	☐
Clinical Intake	☐	Itemized Bill	☐	ETOH Assess/ Psychosocial Eval	☐
Other, (specify)	☐	______________			

Specify purpose of request ____

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Disclose to:	**Request from:**
Name of Person **Facility**	**Name of Person** **Facility**
Address **City** **State** **Phone Number**	**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 Healthcare, 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 Healthcare 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: ______________________

M.INTCORR