ArnotHealth

Authorization for Release of Medical Information/Image to the General Public

Form 8524.52 STK (7/14)

Patient name_____Date of Birth_____

Address_____

City/State/Zip Code_____

Phone ( )_____Medical Record Number_____

I authorize Arnot Health to release information to the general public about my diagnosis, treatment, and/or prognosis for the purpose of: (check all that apply)

□ Arnot Health promotional or educational materials
□ Education of health care professionals outside of Arnot Health (conferences, publications, classes, etc.)
□ News Media_____
□ Other_____

Type of Protected Health Information to be Disclosed: (check all that apply)

□ Patient's verbal/written description of care experience or treatment/illness/injury
□ Provider's verbal/written description of care provided for illness/injury
□ Patient image (photo, video etc.)
□ Other disclosure (specify)_____
Specify illness/injury_____
Dates_____

Authorization Valid:

□ This request only
□ Until (specify dates)_____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to Corporate Compliance Department, Arnot Health, 600 Roe Avenue, Elmira, NY 14905, except where a disclosure has already been made in reliance on my prior authorization.
- The information stated above could be redisclosed if the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations.
- Chemical dependency treatment records and HIV related information require additional authorization.

Signature of Patient or Representative_____**Date**_____

Relationship to Patient_____

□ Copy given to patient

□ Copy placed in chart