# AUTHORIZATION FOR RELEASE OF INFORMATION

**AOMC Form 8710.48H SJH Form 642.23H (6/12)**

ArnotHealth

**Persons/organizations providing the information:**

❑ **St. Josephs' Hospital**
555 St. Joseph's Blvd.
Elmira, NY 14901
Phone: 607-733-6541
Fax: 607-737-7018

❑ **Arnot Ogden Medical Center**
600 Roe Ave.
Elmira, NY 14905
Phone: 607-737-4302
Fax: 607-737-4403

❑ **Ira Davenport Memorial Hospital**
7571 State Route 54
Bath, NY 14810
Phone: 607-776-8727
Fax: 607-776-8623

❑ **AMS Offices**
600 Ivy St., Ste 102
Elmira, NY 14902
Phone: 607-737-4500
Fax: 607-737-7700

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form.

| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Patient Address:** | **Patient Phone:**<br>❑ **Check box if we cannot leave a voicemail** |

**Persons/organizations receiving the information:**

**Specific description of information (including dates)**

- ❑ Abstract (all dictated notes, face sheets, labs, X-rays, EKGs)
- ❑ History & Physical
- ❑ Consultation
- ❑ Discharge Instructions
- ❑ Discharge Summary
- ❑ Entire Emergency Record
- ❑ Operative Note
- ❑ Pathology Records
- ❑ Anesthesia Record
- ❑ Radiology Records
- ❑ Labs
- ❑ Physical Therapy
- ❑ Hand Management
- ❑ Other: _____

**Dates of Treatment:**

1. What is the purpose of the request?

2. I understand that this authorization will expire on ___/___/___ or upon compliance with the request for information, whichever occurs first. **Initials:**

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. **Initials:**

**Drug, Alcohol, HIV and Psychiatric Exclusion**

❑ Check this box ONLY if you do not consent to the release of drug, alcohol, HIV and/or psychiatric information.
** This form is not valid for records pertaining to the Behavioral Science Unit, STARS Program and New Dawn Program. Please contact facility where treatment occurred. **Initials:**

_____ _____
**Signature** **Date**

Relationship, if not patient: _____

_____ _____
**Witness** **Date**

To be Completed by Arnot Health Staff: Date Completed: _____ Initials: _____

MR#: _____ Number of Pages Delivered: _____ ❑ Mailed ❑ Faxed ❑ Hand Delivered

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

New York State Department of Health
AIDS Institute

# Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only 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 New York 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 health 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 more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

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

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related 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: _____

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):

_____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Complete information for each facility/person to be given general 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 health and/or HIV-related information:

Reason for release, if other than stated on page 1:

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

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

Reason for release, if other than stated on page 1:

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 City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health 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 health 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 _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Complete information for each facility/person to be given general 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 health and/or HIV-related information:

Reason for release, if other than stated on page 1:

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

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

Reason for release, if other than stated on page 1:

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

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

Reason for release, if other than stated on page 1:

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 _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**