MONTEFIORE NYACK HOSPITAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Montefiore Nyack Hospital to release the following information from the medical records of:

_____

NAME OF PATIENT | DATE OF BIRTH | TELEPHONE NUMBER

RELEASE THE REQUESTED RECORDS TO:

PATIENT

Name of the Patient _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

Email _____, I understand that in order to receive this information in electronic format, I must provide my email address on this form and that I must also send an email from that address to ROI@montefiorenyack.org.

ATTORNEY

Name of the Attorney _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

OTHER INDIVIDUAL/COMPANY

Name of the Other/Individual _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

MEDICAL RECORDS TO BE RELEASED (PLEASE SPECIFY THE DATES OF SERVICE)

An abstract of your medical record will be released which includes physician documentation, labs, radiology reports, and test results unless you request the entire medical record.

Please select all that apply:

☐ ER RECORD ☐ INPATIENT RECORD ☐ OUTPATIENT RECORD ☐ IMAGES ☐ BILLING

If you would like a specific document, please list it here: _____

Initial: _____Alcohol/Drug Treatment _____Mental Health Information (excluding Psychotherapy Notes) _____HIV - Related Information ____Deceased

PLEASE READ AND COMPLETE THE FOLLOWING:

I understand that I may revoke this authorization at any time by notifying Montefiore Nyack Hospital in writing, but if I do, it won't have any affect on any actions they took before the received revocations. You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days (six months) from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. I further understand that the specific type of information to be disclosed may, if applicable, include: Diagnosis, Prognosis, and treatment for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection for any admissions.

I understand that this authorization will expire on the following date: ___/___/_____ Initials: _____

_____ _____

DATE | SIGNATURE OF PATIENT

_____ _____

PARENT OR GUARDIAN [ ] Health Care Proxy [ ] Power of Attorney | CONSENT OF MINOR (WHEN APPLICABLE)

Montefiore Nyack Hospital
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845-348-2527 Office
845-348-8433 Fax
ROI@montefiorenyack.org

Montefiore | Nyack