AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records Released From:	Records Released To:

Patient Name: _____ **Date of Birth:** _____ **SSN:**_____

Address: _____

Telephone: Home: _____ **Work:** _____ **Other:** _____

This authorization covers the services provided during the period of ___/___/___ (mm/dd/yy) to ___/___/___ (mm/dd/yy)

I would like to □ **Review** □ **Copy** □ **Release the following information: (check all that apply)**

□ History and Physical Examination
□ History and Physical Report
□ Laboratory Test Results
□ AIDS or HIV Infection/Testing
□ Treatment for alcohol and/or drug abuse
□ Progress Notes
□ Discharge Summary
□ Pathology Reports
□ ER Records
□ Clinic Visit Notes
□ X-ray Reports Results
□ X-Ray Films
□ Consultation Reports
□ Surgery Reports
□ Billing Records
□ Mental Health of Psychiatric Services (excluding psychotherapy notes*)
□ Photos, Videos, Other Images
□ Other (please specify): _____

*Release of Psychotherapy Notes, as defined by HIPAA Regulations, requires a separate authorization.

1. My initials specifically authorize the release of any of the following kinds of information that are or may be in my record (initial all that you think may apply and you agree to):

___ AIDS/HIV Infection or Venereal Disease ___ Treatment of Alcohol/Drug Abuse ___ Psychiatric Services

2. This information is to be disclosed for the purpose of:
□ Continuing Health Care □ Insurance □ Legal Purposes □ Change of Primary Care
□ Other (specify):_____

3. 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.

4. This facility, and the North Shore Medical Center, its employees, officers, and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.

5. The patient or the patient's representative must read and initial the following statements:
a. ____ I understand that this authorization will expire one year from the date signed below or upon the following event or condition: _____ unless revoked earlier.
b. ____ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revocation.
c. ____ I understand that the provider/facility reserved the right to collect reasonable fees for the copies I have requested.

(Form MUST be completed before signing)

Signature:_____ Print Name: _____ Date: _____