

## AUTHORIZATION FOR RELEASE OF INFORMATION (For Record Release from Arnot Ogden Medical Center)

<p><b>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.</b></p>																
<p><b>Patient Name:</b></p> <p><b>Patient Address:</b></p>	<p><b>Date of Birth:</b></p> <p><b>SS Number:</b></p> <p><b>Patient Phone:</b></p>															
<p><b>Persons/organizations providing the information:</b>                  Arnot Ogden Medical Center                  600 Roe Avenue                  Elmira NY 14905                  Phone: 607-737-4302                  Fax: 607-737-4403</p>	<p><b>Persons/organizations receiving the information:</b></p>															
<p><b>Specific description of information</b> <span style="float: right;"><i>Requestor will be charged in accordance with New York State Laws.</i></span></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Abstract (all dictated notes, face sheets, lab, X-rays, EKGs)</td> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Radiology Records</td> </tr> <tr> <td><input type="checkbox"/> History &amp; Physical</td> <td><input type="checkbox"/> Entire Emergency Record</td> <td><input type="checkbox"/> Labs</td> </tr> <tr> <td><input type="checkbox"/> Progress Notes</td> <td><input type="checkbox"/> Operative Note</td> <td><input type="checkbox"/> Doctor's Orders</td> </tr> <tr> <td><input type="checkbox"/> Consultation</td> <td><input type="checkbox"/> Pathology Records</td> <td><input type="checkbox"/> Nurses Notes</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Anesthesia Record</td> <td></td> </tr> </table> <p>Other: _____ <b>Type of access requested:</b> Inspection _____ Copies _____</p>		<input type="checkbox"/> Abstract (all dictated notes, face sheets, lab, X-rays, EKGs)	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Entire Emergency Record	<input type="checkbox"/> Labs	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Operative Note	<input type="checkbox"/> Doctor's Orders	<input type="checkbox"/> Consultation	<input type="checkbox"/> Pathology Records	<input type="checkbox"/> Nurses Notes		<input type="checkbox"/> Anesthesia Record	
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	<input type="checkbox"/> Anesthesia Record															
<p><b>Date(s) of Hospitalization Requested:</b></p>																
<p>1. What is the purpose of the use or disclosure? _____</p>																
<p>2. I understand that this authorization will expire on ___/___/___ or upon compliance with the request for information, whichever occurs first. <b>Initials:</b> _____</p>																
<p>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 effect on any actions they took before they received the revocation. <b>Initials:</b> _____</p>																
<p><b>Drug, Alcohol, and Psychiatric Exclusion</b></p> <p><input type="checkbox"/> Check this box ONLY if you do not consent to the release of drug, alcohol, and/or psychiatric information. <b>Initials:</b> _____</p>																
<p>_____ Signature</p>	<p>_____ Date</p>															
<p>Relationship, if not patient: _____</p>																
<p>_____ Notary Public/AOMC Witness</p>	<p>_____ Date</p>															
<p>To be Completed by AOMC Staff – Date Completed: _____ Initials: _____</p>																
<p>MR #: _____ Number of Pages Sent: _____ <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Hand Delivered</p>																