AUTHORIZATION TO RELEASE INFORMATION

Form HIS 8710.48k (12/18)

ArnotHealth

Persons/organizations providing the information:

❑ St. Joseph's Hospital	❑ Arnot Ogden Medical Center	❑ Ira Davenport Memorial Hospital	❑ Outpatient Physician Offices
555 St. Joseph's Blvd.	600 Roe Ave.	7571 State Route 54	600 Ivy St., Ste 102
Elmira, NY 14901	Elmira, NY 14905	Bath, NY 14810	Elmira, NY 14905
Phone: 607-733-6541	Phone: 607-737-4302	Phone: 607-776-8727	Phone: 607-737-4500
Fax: 607-737-7018	Fax: 607-737-4403	Fax: 607-776-8623	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:** ❑ **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 and New Dawn Program. Please contact facility where treatment occurred. **Initials:**

____ ____

Signature **Date**

Relationship, if not patient:____

To be Completed by Arnot Health Staff: Date Completed:___________________________ Initials: __________

MR#: ___________________ Number of Pages Delivered: __________ ❑ Mailed ❑ Faxed ❑ Hand Delivered