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:** ❑ **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