Schuyler HOSPITAL
A Member of Cayuga Health System
HEALTH INFORMATION MANAGEMENT DEPARTMENT
220 Steuben Street
Montour Falls, New York 14865
Phone: (607) 535-7121 Fax: (607) 535-6210

INTERNAL OFFICE USE:
Date Received: _____
Request #: _____
Pending Actions: _____
_____
_____
Date Complete: _____
Completed by: _____
M#/eCW#: _____

1. **This form, when signed, will authorize _____ to disclose specified protected health information about the person named below.**

2. **Patient Name: _____ Date of Birth: _____**

3. **Records requested: _____ Date(s) of service: _____**

4. **Who are these records being shared with? _____**

5. **How would you like these records sent? Check all that apply:**

   ☐ **Mail records to: _____**
   _____
   _____
   _____

   ☐ **Fax records to: (_____)_____-_____**
   (Note: We do not fax to patients. Records for personal use must be mailed or picked up.)

   ☐ **Hold for pickup by: _____** (photo ID required)

6. **I acknowledge the following statements:**
   - I understand that Schuyler Hospital may not condition treatment, payment, enrollment or eligibility for benefits based on the completion of the authorization.
   - I understand that I may revoke this authorization at any time by notifying Schuyler Hospital in writing of my intent to revoke this authorization. If I do notify Schuyler Hospital in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by Schuyler Hospital taken before the revocation. Further details may be found in the Notice of Privacy Practices.
   - Unless otherwise revoked, I understand that this authorization will expire 60 days from the date this form is signed or on the following date or event: _____.
   - I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient because it may no longer be protected by federal privacy regulations.
   - I understand that Schuyler Hospital will give me a copy of this authorization form after I sign it.
   - **This authorization is voluntary, and I may refuse to sign this authorization.**

7. **Signature: _____ Date: _____**

Patient's representative (print): _____ Relationship: _____
Patient's representative must present legal documentation that authorizes them to act on the patient's behalf.