Cayuga HEALTH

Authorization to Release Information

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. **FEES: Health records will be sent to another healthcare provider free of charge as a professional courtesy. All other requests are subject to fees of $.75 per page. Health records are released upon payment of all fees.**

Name - Last, First, MI (Maiden or former name)			Date of Birth
Street Address	City	State	Zip Code
Phone			

Specific description of Information (including dates): _____ **Date Needed:** _____

☐ Abstract (all dictated notes, labs, Radiology Reports, EKGs)	☐ Discharge Summary	☐ Radiology Report	☐ Disc
	☐ History & Physical	☐ Emergency Record/Urgent Care	
☐ Labs/Pathology	☐ Consultation	☐ Operative Report	
☐ Physical Therapy	☐ Cardiac/EKG	☐ Other: _____	☐ Office Notes

Drug, Alcohol, HIV and Mental Health
I authorize by initialing any of the below, that they shall be included in this request:
Drug _____ Alcohol _____ Mental Health _____ HIV _____

Format for Record Delivery: (Select ONE) ☐ Paper ☐ DVD (required PDF viewer) ☐ Other (specify): _____

Please note: If a format is not selected, records will be provided in paper format.

☐ **Release Information FROM: (Select One)**
- ☐ Cayuga Medical Center
- ☐ Cayuga Medical Associates
- ☐ Schuyler Hospital

Name - (e.g. Health Facility, Provider)

Address

City State Zip

Phone Fax

☐ **Release Information TO: **Need Full Mailing Address****
- ☐ Cayuga Medical Center (Fax 607-274-4131)
- ☐ Cayuga Medical Associates (Fax 607-277-0104)
- ☐ Schuyler Hospital (Fax 607-535-6210)

Name - (e.g. Insurance Company, Lawyer, Provider, Patient)

Address

City State Zip

Phone Fax

What is the purpose or need for disclosure?

I understand I may revoke this authorization at any time by presenting written revocation to the Health Information Management Department. Revocation will not apply to information already released in response to this authorization. I understand that any release of information carries with it the potential for redisclosure by the recipient and may not be protected by the federal privacy rules. Cayuga Health will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date or event) _____. If you leave blank, the authorization will expire after 6 months. The patient may request a copy of this authorization.

_____ _____
Signature **Date**

Relationship, if not patient: _____

Cayuga HEALTH

Authorization to Release Information

Please follow the instructions below for filling out the Authorization form:

- Complete patient information: Name, DOB, complete address and contact phone number for any questions.
- Description of Information: Dates of service (exact, time span or event), Date request is needed by, if any. Please mark the check boxes for the information being requested (if not listed, write in under "other")
- ***When releasing sensitive information: Alcohol/Drug treatment, Mental Health programs, HIV/AIDS related information, you must initial boxes. If appropriate fields are not initialed, sensitive information will be redacted. ***Sensitive Information boxes must be INITIALED***
- Complete how you would like to receive the information.
- Choose a location you want the records to come from or complete the location with address, phone and fax number.
- Complete the purpose for your request.
- Enter an expiration date or if no expiration date is written, it will expire 6 months from date of signature.
- Sign and date Authorization: Form must be signed and dated by the patient/legal representative (please provide the relationship of legal representative and any required documentation to support representative) to be valid.

Authorization for Release of Information forms can be found at:

- All Cayuga Health reception areas.
- Online: cayugamed.org, under contact us, click blue link for form. Print, complete and return.
- Mail/Email: We are happy to mail or email a request to you at your request.

Return of completed forms:

- Cayuga Medical Center, Health Information Dept., 101 Dates Dr., Ithaca, NY 14850
  Fax 607-274-4131; Email medicalrecords@cayugamed.org Questions call: 607-274-4314 option 2.
- Schuyler Hospital, Health Information Dept., 220 Steuben St., Montour Falls, NY 14865
  Fax 607-535-6210; Email medicalrecords@schuylerhospital.org Questions call: 607-535-8614.
- Cayuga Medical Associates, Medical Records, 1301 Trumansburg Rd., Suite B, Ithaca, NY 14850
  Fax 604-272-1697; Email Medical_Records@cayugamedicalassociates.org
  Questions call: 607-277-2365 option 6