ST. JOSEPH'S HEALTH
Hospital
A Member of Trinity Health

S J H 2 9 2

AUTHORIZATION FOR RELEASE OF INFORMATION – ST. JOSEPH'S HEALTH
301 PROSPECT AVENUE – ROOM 1606
SYRACUSE, NY 13203 PHONE: 315-448-5160 FAX: 315-448-6227

Patient Name:	Date of Birth: / /
Patient Address:	Phone: ( ) -

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy rule of the Health Insurance Portability And Accountability Act of 1996(HIPAA).

1. I understand that this authorization is voluntary and I may revoke it at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, **CONFIDENTIAL HIV- RELATED INFORMATION and GENETIC TESTING** only if I place my initials on the appropriate line in Item 8.
4. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties if the recipient(s) on this form is not required to protect this information and such information is no longer protected by state and federal law.
5. If I am authorizing the release of HIV-related, alcohol or drug treatment or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under state and federal law.

6. Name and address of **provider to release** this information:

7. Name and address/fax number to whom this information **will be sent**:

8. Specific Information to be released:

( ) Medical record from date_____to date_____

( ) Entire medical record including patient histories, office notes, test results, radiology studies, films, referrals and records sent from other healthcare providers.

( ) Other:_____ **INCLUDING - INDICATE BY INITIALING:**

_____**Alcohol/Drug Treatment**

_____**Mental Health Information**

_____**HIV-Related Information**

_____**Genetic Testing Information**

( ) Authorization to discuss health Information.

By initialing here_____I authorize verbal discussion of my health information.

Purpose of release: ( ) Legal ( ) Insurance ( ) Disability ( ) coordination of care ( ) Transfer of care*
( ) at request of individual ( ) other_____
This authorization is good for one year unless otherwise indicated.

_____ _____
Signature of patient or representative authorized by law Date
If not patient, authority to sign:

_____

** If you are sending medical records **to** St. Joseph's Health for transfer of care please fax records to 315-744-1967 or mail to HIM North Medical Center 5100 West Taft Road Suite 1W Liverpool, N.Y. 13088