ST. JOSEPH'S HEALTH
A Member of Trinity Health

AUTHORIZATION FOR RELEASE OF INFORMATION

ST JOSEPH'S HEALTH-HIM
301 PROSPECT AVENUE
SYRACUSE, NY 13203 **PHONE: (315) 448-5160**

FAX COMPLETED REQUEST FORM TO: **(315) 448-6227**
OR EMAIL TO: **STJOSEPHSSYRACUSE@MROCORP.COM**
(Please do not send patient records to this fax number, use number on bottom of form)

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), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV-RELATED INFORMATION** only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. 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 federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization 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 on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditions upon my authorization of this disclosure.
5. Information disclosed under this authorization might be disclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. Records being sent from:	**7. Send records to:**
PROVIDER NAME:	**NAME:**
FACILITY:	**FACILITY:**
ADDRESS:	**ADDRESS:**
CITY, STATE, ZIP:	**CITY, STATE, ZIP:**
FAX #: ( )	**FAX #: ( ) EMAIL:**

8. Specific Information to be released:

***REQUIRED- Dates of service- From: __/__/__ To: __/__/__**

( ) Abstract	( ) Face Sheet/Demographics	( ) Lab Reports	( ) Pathology Reports
( ) EKG/ECG/Cardiac Testing	( ) Discharge Summary	( ) Medication Records	( ) Radiology Images
( ) Entire Record	( ) History and Physical	( ) Operative Notes/Procedure Reports	( ) Radiology Reports
( ) ER Record	( ) Itemized Billing Record	( ) Other:_____	

9. Authorization to release protected information:

***REQUIRED -** Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one

☐ **I DO** ☐ **DO NOT**	want information about * **Alcohol and or Substance Abuse** released	PLEASE INITIAL_____
☐ **I DO** ☐ **DO NOT**	want information about * **Mental Health** released	PLEASE INITIAL_____
☐ **I DO** ☐ **DO NOT**	want information about * **HIV-Related Information** released	PLEASE INITIAL_____
☐ **I DO** ☐ **DO NOT**	want information about * **Genetic Testing** released	PLEASE INITIAL_____

STOP Please confirm that you have put a checkmark AND initialed all protective information categories above regardless if they apply or not. If form is incomplete, or if the protected information is not checked and initialed we may be unable to fulfill this request

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 with the date: _____

Signature of Patient/Parent or Legal Guardian _____ **Date:**

(Legal representation documentation must be supplied if not patient)

**** If you are sending medical records to St. Joes and it is less than 50 pages you can fax to: (315) 744-1967**
or mail to: HIM Department 301 Prospect Avenue Syracuse, NY 13203