Glens Falls Hospital
Authorization for Release of Information

Medical Record Number: _____

PATIENT NAME: _____ **DATE OF BIRTH** _____

ADDRESS: _____ **PHONE NUMBER** _____

I, the undersigned, being patient/ parent/ legal guardian / legal representative authorize Glens Falls Hospital to release and/or disclosure of the above named individuals health information.

PATIENT INFORMATION TO BE RELEASED: (Check all boxes that apply)
(Inclusive of Drug Abuse, Alcohol, HIV/AIDS, Mental Health-Psychiatry)

□ Abstract Medical Record	□ ER Record	□ Radiology/Diagnostic Imaging Report
□ Consultation	□ History and Physical	□ Psychiatry Evaluation
□ Complete Medical Record	□ Lab Report	□ PT/OT/Speech/Audiology
□ Discharge Summary	□ Operative Report	□ OTHER_____

PROVIDER or OUTPATIENT VISIT OFFICE: _____

DATES OF SERVICE TO BE RELEASED: From: _____ To: _____

PURPOSE: _____ **INFORMATION TO BE:** □ Pick up □ Mailed

AUTHORIZATION TO RELEASE TO:

NAME: _____
ADDRESS: _____

There is a fee for copies of medical records, regulated by New York State Law. ___ (initial)
I understand I have the right to revoke this authorization at anytime and that it must be done in writing. I understand that this revocation does not apply to information that has already been released. I understand that this revocation does not apply to requests from Government Agencies, Insurance Companies and certain Law Enforcement Officials, etc., who are entitled to the information without authorization under HIPAA, Federal Regulations and State Regulations. This authorization will expire within one year of signing or until (date)_____ (visits passed the date of signature will not be honored).

I understand that I may review the information and/or retain a copy of the information to be disclosed (refer: 45CFR 164.524). I understand that any disclosure of information has the potential for unauthorized disclosure or re-disclosure and that I may not be protected by Federal and State Privacy / Confidentiality Regulations. I understand that if I should have any questions, I can contact the Director, Health Information Management or HIMS Correspondence Staff at Glens Falls Hospital. I understand that under certain circumstances, that I may be required to produce supporting legal documentation in cases of Custody, Proxy, Foster Children, Executor of the Estate, etc.

_____
Signature of Patient, Parent, Legal Guardian Date

_____
Relationship to Patient

_____
Signature of Emancipated Minor Date
(as appropriate – Court Documentation required)

Notice to recipient: This information has been disclosed to you from medical records whose confidentiality is protected by Federal and State Regulations. These regulations prohibit you from re-disclosure without the written consent of the patient / parent / legal guardian or otherwise permitted by specific regulations. Anyone who receives this information covered by these regulations obtained legally or not, is prohibited by law from using the information for any criminal or civil investigation (42 CFR Part 2, 45 CFR 164, NYS Title E-Article 13, NYS Title 10 Chapter V Article 2 Part 405)