Oneida Health

PATIENT REQUEST & AUTHORIZATION FOR HEALTH INFORMATION (Including Deceased Patients)

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OH may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization. You have the right to a copy of your health information. Usually, this includes medical and billing records, but does not include psychotherapy notes. OHC may deny your request in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

PATIENT NAME: (PRINT) _____ **DATE of BIRTH:** _____

TO BE RELEASED TO: ☐ **Patient** ☐ Qualified Representative **Name:** _____

Address: _____ **EMAIL ADDRESS:** _____

City: _____ **St:** _____ **Zip:** _____ **Ph:** _____ **Fax:** _____

DELIVER VIA: ☐ Mail ☐ Secure Email ☐ Fax ☐ Hand Delivered (ID verified) by: Initial here _____

Paper Copies: The first 15 pages are free. Starting at page 16, the fee will be 75 cents per page, with a maximum fee of $25.

CD/DVD: $25 **CD for X-Ray Film**: $5 **Fax:** No Charge **Secure email** for 15 pages or less only**:** No Charge

Access to Deceased Patient's Information: As per Public Health Law §18, substantiating proof and authorization below must be provided to validate that the requestor is one of the following qualified persons.

[ ] DISTRIBUTEE: I am the patient's (indicate relationship) _____ and testify that an administrator or executor of the estate has not yet been appointed. **A copy of a certified copy of the death certificate is enclosed.**

[ ] EXECUTOR OF ESTATE: I am the patient's administrator or executor of estate. **A copy of the Letter of Administration or Letters Testamentary issued by the Surrogate Court is enclosed.**

[ ] ATTORNEY HOLDING POWER OF ATTORNEY: I am acting as the POA for the estate/distributee. **Enclosed is a copy of the POA** which explicitly authorizes my authority to request patient information, and **a copy of the certified copy of the death certificate.**

HEALTH INFORMATION REQUESTED FOR THE PURPOSE OF: _____

HEALTH INFORMATION REQUESTED: **PCP** (physican):_____ **Specialty Office** (physician):_____ **Hospital**:_____

Dates of service to be released: **FROM**: _____ **TO:**_____

[ ] Complete Record	[ ] Hospital Summary	[ ] Office Records	[ ] Emergency Room Records
[ ] Physician Reports	[ ] X-ray Reports	[ ] Cardiac Reports	[ ] Lab Reports
[ ] Diagnostic Tests	[ ] Pathology Report	[ ] Immunizations	[ ] X-Ray Films

[ ] Other: _____

AUTHORIZATION:

_____ _____

PRINT NAME of Patient or Parent/Guardian or Other Qualified Individual — Relationship to Patient, if applicable

_____ _____

SIGNATURE — Date

☐ **VERBAL CONSENT** was provided by the Patient and received by: _____ Date: _____

Oneida Health / Oneida Health Extended Care Facility / Oneida Health Practices & Affiliates
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* H I M R E Q P A T I N F O *