Oneida Health
Oneida Health Extended Care Facility
Oneida Health Practices & Affiliates
321 Genesee St. • Oneida, NY 13421
Ph.: (315) 361-2027 Fax: (315) 361-2227

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Pt Name (Print): ______________________________ **DOB:** ____________________

MR / Acct #: ______________________________ **Phone: H**__________**W**__________

Pt Address: ____

I, or my authorized representative, request the health information pertaining to my care and treatment, during the time period indicated, be released as noted below. I understand that health information being released may include information relating to sexually transmitted disease, HIV, behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in six (6) months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and will no longer be protected by the Privacy Act. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. If I have questions about disclosure of my health information, I can contact the Oneida Healthcare's Director of Health Information Management at (315) 361-2027.

If the records requested are that of a **Deceased Patient**; a certified copy of the death certificate must be attached along with substantiating proof and authorization to validate that the requestor is either; a Distributee, Executor of the Estate, or Attorney holding Power of Attorney.

I AUTHORIZE THE FOLLOWING ORGANIZATION TO DISCLOSE THE RECORDS:

Name and Address: ____

Dates of Service to be released: FROM: ______________________ **TO:** ______________________

Type and amount of information to be released (include dates where appropriate):

- ☐ Complete Record
- ☐ Physician Reports
- ☐ X-ray/Imaging reports
- ☐ X-Ray Films
- ☐ Other: (Please specify)
- ☐ Hospital Summary
- ☐ Pathology Report
- ☐ Diagnostic Tests
- ☐ Office Records
- ☐ Emergency Room Record
- ☐ Lab reports
- ☐ Cardiac reports
- ☐ Immunization record

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THE INFORMATION IS TO BE SENT TO:

Facility/Provider Name: ______________________________ Phone#: ____________________

Address: ______________________________ Fax#:____________________

RELEASED FOR THE PURPOSE OF: ______________________ Date needed: ______________

AUTHORIZATION:

____ ______________________
Patient or Parent/Guardian or Other Qualified Individual Signature Date

____ ☐ Verbal Consent was provided by the patient
If other than patient, Relationship/Authority

____ ______________________
Signature *of person accepting the verbal consent* Date / Time

5/02 Policy 1-9a rev: 6/10, 9/19, 06/20, 03/22
EDM (00144) HIM-Authorization for Disclosure of Health Information