ALBANY MED Health System

Health Information Management

Authorization to Disclose Protected Health Information

Patient Information

Patient Name *(First, Middle, Last)*		
Date of Birth *(mm/dd/yyyy)*	Medical Record Number	
Current Mailing Address		Apartment/Unit#
City	State	ZIP
Contact Phone #	Email address *(if any)*	

General Types of Information to be Released to Recipient

Dates of Service *(mm/dd/yyyy)* **to** *(mm/dd/yyyy)*

☐ Billing Records	☐ ER Report	☐ Urgent Care Report	☐ Primary Care Office notes
☐ Specialty Office Notes	☐ Laboratory Results	☐ Radiology Reports	☐ Radiology Images
☐ Discharge Summary	☐ Operative Reports	☐ History & Physical	☐ Entire Record
☐ Other			

Release Information From:

☐ Albany Medical Center	☐ Columbia Memorial Health	☐ Glens Falls Hospital	☐ Saratoga Hospital
☐ Urgent Care/Emergent Care (Location, etc.)			
☐ Primary Care (Provider name, location, etc.)			
☐ Specialist (Provider name, location, etc.)			

Sensitive Types of Information to be Released to Recipient *(please initial all that apply):*

Alcohol/Drug Treatment	Mental Health Related Information	HIV-Related Information	Genetic Testing Information

Please note that if any of the above sensitive types are selected, a Release of Information Department team member will be in touch to ensure your request is filled out in accordance with Federal & NYS regulations

Release Information To:

Name of Recipient	Purpose of Disclosure *(Continuity of Care, Personal Use, Legal, etc.)*
Address of Recipient	City State ZIP
Phone Number of Recipient	Fax Number of Recipient

How Would You Like Your Information Released?

Choose one:

☐ **Email Address** _____

☐ **Fax Number** _____

☐ **Mail** (☐ CD or ☐ USB Drive)_____

☐ **Pick Up In-Person** (☐ CD or ☐ USB Drive)_____

Make your request through MyChart, the Albany Med Health System's secure online patient portal. Log in or create an account at **mychart.albanymed.org**

Please see page 2 for more information and to sign

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on _____. **If I fail to specify an expiration date, event or condition, the authorization will expire in 90 days.** I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy rules or New York law. I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. **I understand the fee for copies of my medical record is $0.75 cents per page. This fee will be waived if the records are being sent to another physician or for continuing treatment.**

I hereby authorize the Albany Med Health System to disclose or permit use of health information, as described below, concerning the above-named individual. I understand that federal and state law offer special protection for information relating to **sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or the human immunodeficiency virus (HIV). Similar protections exist for information about behavioral or mental health services, and treatment for alcohol and drug abuse.** I understand that, if the health information covered by this authorization contains such information, I am waiving those protections in this instance by voluntarily authorizing use or disclosure of the health information.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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** or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If these records are covered under Federal confidentiality rules (42 CFR Part 2), this rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Requesters Signature:

Signature of Patient or Legal Representative	Date
If Signed by Legal Representative, Relationship to Patient	Date
Patient or Legal Representative Name (Print)	Date