Authorization for Release of Protected Health Information

Carthage Area Hospital

The Place for Personal Care

1001 West Street, Carthage, New York, 13619 (315) 493-1000

Patient Name	Birth Date	Social Security Number	MR #

Address	Phone Number

I hereby authorize Carthage Area Hospital and/or their extension clinics to disclose or obtain protected health information from the medical record of the above-named patient to:

_____

Name & Address of Person/Organization where disclosure is to be made or obtained from

For the following purpose: _____

For the following dates of service (must be completed): _____

_____

Types of Access Requested

□ Copies of Record **OR** □ View record only

□ Entire record	□ Labs	□ Operative Report
□ Emergency room	□ Radiology	□ Pathology Report
□ History & Physical	□ EKG	□ Progress Notes
□ Consultation	□ Discharge Summary	□ Other _____

I authorize Carthage Area Hospital to discuss my medical condition and/or instructions regarding same, until such time that I state otherwise in writing, with the following individual/s:_____

_____

This authorization expires _____ or unless otherwise specified, 90 days from the date signed below and covers only treatment for the dates specified.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn by me by notifying Carthage Area Hospital's Health Information Management Department in writing at any time, except to the extent that action has been taken in reliance upon it. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Protected Health Information."

_____	_____	_____
Date	Signature of Patient/Parent/Guardian/Healthcare Proxy	Relationship/Authority

_____

Print Name

All fees/charges will comply with all laws and regulations applicable to release of information. Although information should not be re-disclosed, it may be dispersed by another entity during routine treatment, payment, or operations and therefore, would not be covered by Federal Regulations. Federal Register, Department of Health & Human Services, 45 CFR, Standards for Privacy of Individually-Identifiable Health Information, Section 164.524.