CROUSE HOSPITAL
Your care. In our hands.

AUTHORIZATION FOR RELEASE OF INFORMATION

Doc. #5569 Rev. 03/26/2013

Patient Name:_____ Date of Birth:_____

I hereby authorize and request Crouse Hospital to provide access to medical information on the above named patient to:_____

Address: _____

_____

Phone#:_____ Fax#:_____

The purpose of this authorization is for:_____
The information to be released, which may be inclusive to history, diagnoses and treatment information, including psychiatric care and any treatment for alcohol and drug abuse, is as follows:

_____

_____

Any exception to the information to be released is as follows: _____

_____

The request for information is limited to admission or hospital services commencing _____ and ending _____ .

I understand that I may refuse to sign this authorization. My treatment will not be conditioned on signing this authorization. I may revoke this authorization at anytime by writing to the Privacy Officer at Crouse Hospital, Health Information Management, 736 Irving Ave, Syracuse, NY 13210. Such revocation will not affect any use or disclosure already taken in reliance upon this authorization. This authorization will automatically expire 365 days after the date of signature.

I understand that once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws. Crouse Hospital is released from all legal responsibilities which may arise from the release of requested information.

Please be advised that a fee of $.75 per page may be charged for all paper medical records copied/printed. Medical records can also be provided on CD (PDF Format) for $.35 per page/image. **Please note:** Electronic medical records requested on CD are only available if the medical record is dated from 07/01/2010 to present. Records requested that are dated prior to 07/01/2010, will be in paper format.

Please select one of the following. I would like my medical records in: ❑ Paper Format
❑ Electronic Format (CD)

_____ _____ _____
Date Time Signature

_____ _____ _____
Date Time Signature of Authorized Rep

_____
Print Authorized Rep's name

_____
Basis for legal authority if signed by Authorized Rep

White copy-ROI Yellow Copy-patient