



**AUTHORIZATION FOR
RELEASE OF INFORMATION**

Doc #5569 Revised 4/21/2020

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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 be provided on CD (PDF Format) for a \$6.50 flat rate. **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 older than 10 years are subject to retention and destruction policy and procedure.

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