Thompsonhealth

Return to:

350 Parrish Street
Canandaigua, New York 14424

Supporting Instruction# IM.03.025.00.01
Effective Date: 10/31/2004

Authorization for Release/Use of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____ Phone#: ( ) _____

City/State/Zip _____ SS# _____

PURPOSE FOR THIS REQUEST: ❒ Healthcare / Appointment**: Date**_____ ❒ Patient Request ❒ Insurance
❒ Other _____
_____

This Authorization allows Thompson Health to: (check **ONE**)

❒ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

OR

❒ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

_____ _____
Name of Provider / Person / Facility Address

_____ _____
City, State, Zip Code Phone # Fax #

TYPE OF RECORDS / INFORMATION REQUESTED: Check all that apply:

❒ **Inpatient: Dates**_____

(Check only ONE of the following three (3) choices if requesting inpatient records)

❒ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
❒ Specific information or reports _____
(Please describe)
❒ Entire copy of the inpatient dates specified above.

❒ **Outpatient/Office visits: Date(s)**_____ **and/or Specific illness/injury** _____.
❒ **Other** _____
_____
(Please describe)

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)

❒ This request only
❒ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative _____ **Date** _____

Relationship to Patient *(if requester is not the patient)* _____