AUTHORIZATION FOR RELEASE OF INFORMATION

☐ **Orange Regional Medical Center**
707 East Main Street
Middletown, NY 10940
T: 845-333-1531; F: 845-333-1560

☐ **Orange Regional Medical Group** (Name of Specialty) _____
707 East Main Street
Middletown, NY 10940
T: 845-333-7575; F: 845-333-7139

☐ **Catskill Regional Medical Center**
68 Harris-Bushville Rd.
Harris, NY 12742
T: 845-794-3300; F: 845-794-3376

☐ **Catskill Regional Medical Group** (Name of Specialty) _____
68 Harris-Bushville Rd.
Harris, NY 12742
T: 845-791-7828; F:

☐ **Catskill Skilled Nursing Unit**

I hereby authorize the use or disclosure of my individually identifiable health information from my medical record as described below. This may include **medical**, **psychological, neuro-psychological, psychiatric, HIV/AIDS test results or diagnoses, drug and/or alcohol abuse** information. This authorization covers the release of medical records from Orange Regional Medical Center (ORMC), Catskill Regional Medical Center (CRMC) and/or GHVHS Medical Group, PC. I understand that this authorization is voluntary.

Patient Name:		**Today's Date**:
Date of birth:	**Phone Number:**	**How would you like to receive your records**: ☐Paper ☐CD ☐MyChart
Mailing Address:		
Street	City/ Town	State Zip Code

Description of information that may be disclosed:

☐ Emergency Room Record Date(s) of Service: _____
☐ Inpatient Record Date(s) of Service: _____
☐ Outpatient Record Date(s) of Service: _____
☐ Urgent Care Date(s) of Service: _____
☐ Office Visit Date(s) of Service: _____
☐ Other _____ Date(s) of Service: _____

If the requested portion of the record contains information related to drug/alcohol, mental health or HIV related information, you must specifically consent to the release of such information by initialing here_____(must initial)

Persons/Organization receiving the information:

_____
Name

_____
Street Address

_____
City State Zip Phone/Fax

1. The information will be used/disclosed for the following purposes: _____
(NOTE: this item is not required if the disclosure is requested by the patient.)

2. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

3. [If applicable] I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.

4. I understand that ORMC will not be held responsible for disclosure of PHI while in transmission, or for the safeguarding of the information once delivered, pursuant to my request(s) to receive PHI by email

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may see or copy the information used/disclosed under this authorization and that I can get a copy of this form after I sign it.

6. I understand that I may revoke this authorization in writing at any time by notifying the providing organization in writing, but if I do it won't affect any actions they took before they received the revocation.

7. I understand this authorization expires on ____/____/____. **IF DATE IS NOT STATED, THE AUTHORIZATION WILL EXPIRE IN ONE YEAR**.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient