

Instructions: Authorization to Release Protected Health Information Form

Did you know....Your records can be accessed on our patient portal! Ask the front desk if you would like to sign up to our portal! You will need to provide an email address.

<u>Form A:</u> Authorization to Release Protected Health Information

<u>When to use:</u> This form is used when you are requesting copies of your health records for yourself or your child/individual that you have guardianship over **or** if you would like to send these records to another facility/office.

Instructions:

- Section 1: Patient's name, DOB, address and phone number of records requested
- **Section 2**: Add the Name, Address, number and fax number to where the records need to be sent. If you are directly requesting the records, your information would go in this section.
- **Section 3**: Check what health records need to be sent. Add the dates or the date range of the records you want sent.
 - If you choose all medical or all dental, you do not have to choose a date range.
 - Immunizations=vaccinations/shot record
 - Labs=blood work/testing
 - Progress Notes= office visit notes
- **Section 4**: if any of your records that you checked in **Section 3** contain any information regarding mental health conditions, drug/alcohol related conditions and/or HIV/AIDS testing or treatment please **initial** the appropriate boxes so this information can be legally sent.
- **Section 5:** Circle how you would like the records sent/received (if you want to pick them up, mailed, faxed, emailed). If you would like records emailed, please add email address to the line.
- **Section 6:** Circle the reason you want your records released.
- **Section 7:** Need signature of patient or Legal guardian, date and printed name. Relationship to patient if someone other than patient signed (example: guardian, mother, father)





For Internal Use Only:		
S	ignature of Mosaic H	ealth Staff receiving completed form
Patient Account Number	er:	Date:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient	Name:		Date of Birth:						
Addres	S:				Phoi	ne Number:			
				ove patient's					
Name_				Address					
City/Sta	ite/Zip		P	hone#		_Fax#			
Choose	what records Entire Medical Ro	need to be ecord Medication	Entire Dental	<mark>check below:</mark>	леdical X-Ray rd Pro	Dental X-Rays gress Notes			
	ollowing Dates o								
(Example	s: Specific Date-1	L/13/2020; R	ange of Dates-	January-July 201	9)				
*If recor	ds include reprod	luctive recor	ds of a minor	this authorization	n requires m	inor signature.			
	Specific	authorizati	on is require	d to release the	following	locumentation			
						not be released)			
Ale	•		•			_ Mental Health Treatr	ment		
information		nt is prohibite	ed from re-disc			nt, and/or mental health t t my authorization unless			
Format	Requested:	Fax (J.S. Mail	In Person(ID F	Required)	Email			
The Info	rmation is to b	e disclosed	for the follow	wing reason(s):					
I underst authoriza carries w confident individua I underst I must do understa authoriza insurer w	and that authorizing tion. I need not sight it the potential is it the potential is it the regardiant that I have a so in writing and that the revocation. I understand ith the right to continuous in the right to continuous it it the regotation.	ng the disclosing this form if for an unautive questions making discloright to revok present my vation will not a that the revontest a claim	sure of this head in order to asson orized re-disc about disclosusure. The ethis authorization apply to inform ocation will not	alth information is ure treatment. I ur losure and the informeter of my health in ation at any time. I do not the Medical ation that has alreaply to my insurey.	voluntary. I conderstand that ormation may formation, I conderstand Records Department ance compar	Referral/Care Coord an refuse to sign this t any disclosure of inform not be protected by fed- can contact the authorized that if I revoke this author cartment at Mosaic Healt eased in response to this my when the law provides	nation eral d orization, h. I s s my		
	horization expi			(insert date h	ere), or wit	hin one (1) year of the	e date		
of autho	rization, which	ever is less	•						
Signatu	re of Patient/Pa	rent/Legal F	Representativ	<mark>/e</mark>		Date of Signatur	e		
Printed I	Name of Signati	ure Above			telationship	to Patient			
nt Morris Hill Drive 1, Room 140 s, NY 14510 :43-7840 :554-3342	Rushville 2 Rubin Drive Rushville, NY 14 P: 585-554-4400 F: 585-554-334	4544)	Utica-Medic 1651 Oneida Stre Utica, NY 13501 P: 315-793-7600 F: 315-792-0079	al Utica et 3 Parksid Building Utica, NY	I-Dental le Court 1 ′ 13501 93-7600	Lyons 1519 Nye Road Lyons, NY 14489 P: 315-871-3178 F: 585-554-3342	Ilion 55 Central PI Suite B Ilion, NY 133 P: 315-444-1 F: 315-792-0		