



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.

Form A: Authorization to **Release** Protected Health Information

When to use: 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)

A



For Internal Use Only: _____
 Printed Name of Mosaic Health Staff receiving completed form _____
 Patient Account Number: _____ Date: _____

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION

1 Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I authorize Mosaic Health to release the above patient's records to:

2 Name _____ Address _____

City/State/Zip _____ Phone# _____ Fax# _____

Choose what records need to be released, check below:

- 3 Entire Medical Record Entire Dental Record Medical X-Rays Dental X-Rays
 Lab Results Medication List Immunization Record Progress Notes

Other: _____

For the Following Dates of Treatment: _____

(Examples: Specific Date-1/13/2020; Range of Dates- January-July 2019)

***If records include reproductive records of a minor this authorization requires minor signature.**

4 **Specific authorization is required to release the following documentation**
(Indicate by Initialing below, if not initialed information will not be released)
 ___ Alcohol/Drug Treatment ___ HIV/AIDS Related Information ___ Mental Health Treatment

*By specifically authorizing the release of HIV/AIDS related, alcohol or drug treatment, and/or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

5 **Format Requested:** Fax U.S. Mail In Person(ID Required) Email _____

6 **The Information is to be disclosed for the following reason(s):**

- Transfer of Care School/Employment Disability Legal Referral/Care Coordination

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at Mosaic Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires on: _____ (insert date here), or within one (1) year of the date of authorization, whichever is less.

7 _____
Signature of Patient/Parent/Legal Representative **Date of Signature**

Printed Name of Signature Above

Relationship to Patient

Mount Morris
 1 Murray Hill Drive
 Building 1, Room 140
 Mt. Morris, NY 14510
 P: 585-243-7840
 F: 844-683-9216

Rushville
 2 Ruben Drive
 Rushville, NY 14544
 P: 585-554-4400
 F: 844-683-9216

Utica-Medical
 1651 Oneida Street
 Utica, NY 13501
 P: 315-793-7600
 F: 844-683-9216

Utica-Dental
 3 Parkside Court
 Building 1
 Utica, NY 13501
 P: 315-293-7600
 F: 844-683-9216

SBHC
 4100 Baldwin Rd
 Rushville, NY 14544
 P: 585-287-8844
 F: 844-683-9216

Lyons
 1519 Nye Road
 Lyons, NY 14489
 P: 315-871-3178
 F: 844-683-9216
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Ilion
 55 Central Plaza,
 Suite B
 Ilion, NY 13357
 P: 315-444-1900
 F: 844-683-9216