BETH ISRAEL MEDICAL CENTER

2011

AUTHORIZATION FOR RELEASE/PATIENT ACCESS OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____ S.S. #: _____ M.R. #: _____

Street, Apt. #: _____

City, State, Zip Code: _____ Telephone #: _____

1. I hereby authorize the Medical Records Department staff at Beth Israel Medical Center to release information from my medical record to (If self please indicate below):

2. Name _____

   Address _____

   City, State, Zip Code _____ Telephone #: _____

   For the purpose of *(please check one)*

   ☐ Continued Treatment ☐ Legal Review ☐ Insurance purpose

   ☐ Personal review of information ☐ Other (please specify) _____

3. I limit the information to be released to the following items: *(Please check specific items)*

   ☐ Discharge Summary ☐ Consultation ☐ Diagnostic test (e.g. Lab, X-ray, Radiology)

   (Please specify) _____

   ☐ Operative Note ☐ Pathology ☐ Other (please specify) _____

   ☐ Emergency Department Record ☐ Outpatient Record (please specify) _____

Covering records from on or about (Date) _____ to (Date) _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

   _____ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

   _____ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

5. I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. If I experience discrimination because of release of HIV confidential information, I can call the NYS Division of Human Rights at (212) 480-2493 and/or the NYC Commission of Human Rights at (212) 306-7450.

6. This authorization will automatically expire within six months from the date of signature. I understand that I have the 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 Beth Israel Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

8. I also understand that in an effort to prevent unauthorized re-disclosure Beth Israel Medical Center attaches a notice when sending out records that states, “re-disclosure is prohibited”. However, the potential for an unauthorized re-disclosure my not be protected by federal confidentiality rules.

9. I also understand that in order to process this request to reproduce medical record information on a timely basis, Beth Israel Medical Center, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

_____ _____

(Signature of Patient/Representative/ or Legal Guardian) (Date)

_____ _____

(Relationship to Patient) (Notary Witness)