

Instructions For Completing The Authorization For Release Of Health Information Form

Authorization for Release of Health Information Instructions

Please Note: There may be a delay in processing your request if this form is not filled out properly or is incomplete.

1. Enter the name, address, date of birth, telephone number, and e-mail address (*for electronic delivery*) of the **patient** for whom records are being requested. Only include one patient per form.

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

2. Enter the contact information or health care provider or entity to release this information.
 - a. **For hospitals or other entities:** The name of the hospital or entity should be entered in this area (ex. North Shore University Hospital).
 - b. **For Doctor's Office:** The name and address of the doctor must be entered. (example: Dr. Jane Jones at 300 Northwell Drive). If only one doctor is listed, then only that specific location information will be released. If records are needed by more than one person/facility, a separate request *is required*.

1. Contact information or health care provider or entity to release this information (from who):	
Name: XXXXXXXXXXXXXXXXXXXXXXXX	Address: XXXXXXXXXXXXXXXXXXXXXXXX
Phone #: XXXXXXXXXXXXXXXXXXXXXXXX	

3. Enter the complete information of the person(s) or entities who will **receive** this information, along with the address, telephone number/fax/e-mail.

2. Contact information of person(s) or entities who will receive this information (to who):		
Name: XXXXXXXXXXXXXXXXXXXXXXXX	Address: XXXXXXXXXXXXXXXXXXXXXXXX	
Phone #:	Fax:	E-mail:

4. Select the preferred delivery method by checking **ONE** of the choices under delivery manner. The delivery details section is required: If Mail, Electronic Mail or Fax, please include the specific address or phone number. If this information is not included, records will be sent by regular mail.

3. Manner	Form/Format	Delivery Details
<input type="checkbox"/> Regular Mail	<input type="checkbox"/> Paper copy <input type="checkbox"/> Secure USB Flash Drive <input type="checkbox"/> CD	Mailing Address: XXXXXXXXXXXXXXXXXXXXXXXX
<input type="checkbox"/> Pick up at facility	<input type="checkbox"/> Paper copy <input type="checkbox"/> Secure USB Flash Drive <input type="checkbox"/> CD (where available)	N/A
<input type="checkbox"/> Electronic mail	<input type="checkbox"/> Secure email <input type="checkbox"/> Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address: XXXXXXXXXXXXXXXXXXXXXXXX
<input type="checkbox"/> Fax	N/A	Fax Number: XXXXXXXXXXXXXXXXXXXXXXXX
<input type="checkbox"/> Other	Please explain:	

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5. Initial next to "Verbal" to authorize the facility and/or doctor to discuss your health information with the receiving party specified. Note: This section is not required when only requesting copies of medical records.

4. Verbal _____ **PLEASE INITIAL HERE** to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.

6. Enter the specific information you are authorizing Northwell Health to release. If selecting a time frame for the records to be released, it can be for a single date of service or a range of dates or years.
- For a doctor's office, if you are unsure of the time frame, select Medical Record Abstract and the most recent information will be released. A medical record abstract will consist of the following items over the past 1-2 years (or date range specified): Provider/Clinician Documentation, Procedure Reports, Laboratory, Pathology, and Radiology Reports.
 - For a hospital, A medical record abstract may consist of pertinent contents from the patient's most recent discharge (or date range specified) such as: Doctor/clinician Documentation, Testing Results, Procedure Documentation, and Discharge Documentation. if you are unsure of the time frame, contact the facility where you were treated for further information.

5. Requested Health Information:

- ☐ Medical Record Abstract (summary of record)
- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record
- ☐ Laboratory results for date of service _____
- ☐ Radiology images and reports for date of service _____
- ☐ Itemized bill for _____
- ☐ Other: Please explain _____

7. Enter the reason for the release of information: Note: If other, you must give the specific reason, such as litigation or personal use. "At the request of the individual" may be selected when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

6. Reason for release of information:

- ☐ At request of individual ☐ Other: _____

8. Initial this section **ONLY IF OPTING OUT** of the release of substance abuse treatment information, mental health treatment information or HIV-related information.

8. The following types of information may be released unless you or your authorized representative initial in the appropriate spaces provided below to opt out of releasing these types of health information:

- _____ Substance Abuse Treatment Information from an OASAS licensed unit or program¹ only (including diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)
- _____ Mental Health Treatment information from an OMH licensed unit or program² only
- _____ HIV-Related Information

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9. Please enter an expiration date, event or condition upon which the Authorization Form will expire (unless you revoke it earlier). If left blank, the Authorization Form will be returned for additional information. Using "indefinite," is not acceptable. A fixed period of time is required by law (e.g., 6 months, 30 days post discharge, at the end of litigation).

9. Expiration Date or Event

This authorization will expire on (please check one and complete as applicable):

☐ One (1) year

☐ Other (please specify expiration date) _____

*This field must be completed with date or event

10. The person completing this form must sign Patient/Agent/Relative/Guardian and include the date and time the form is signed. Print your name if other than the patient. If an interpreter assists with completing this form, his or her information is to be included below. If there is a witness involved with interpretation, his or her information is also to be included.

XXXXXXXXXXXXXXXXXXXXXXXXXXXX		XXXXXXXXXXXXXXXXXXXXXXXXXXXX	
Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name Relationship if other than patient
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			
Telephonic Interpreter's ID #	Date	Time	
OR			
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			
Witness to signature (Signature)	Date	Time	Print Witness Name
* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.			
¹ Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.			
² Units or programs licensed by OMH only include programs whose specific purpose is the treatment of mental illness.			