UNIVERSITY OF
ROCHESTER
MEDICAL CENTER

STRONG HEALTH

Strong Memorial Hospital
Department
or Practice: ____________________
601 Elmwood Avenue, Box #: ____________
Rochester, NY 14642

Standard Register ®

SH 48 MR Authorization for Release of Medical and/or Behavioral Health Information

Patient's Name: ____________________ Date of Birth: ____________________
Address: ____________________ Patient's Phone #: (______) ____________
City/State/Zip: ____________________ Social Security #: ____________________

PURPOSE FOR THIS REQUEST: ☐ Healthcare / Appointment: date __________ ☐ Insurance ☐ Other

This Authorization allows University of Rochester Medical Center (URMC)/Strong Health to: *(check ONE)*

☐ ***SEND*** copies of your record to (or discuss your information with) the provider/person/facility below

OR

☐ ***RECEIVE*** copies of your record from (or discuss your information with) the provider/person/facility below

____________________ ____________________
Name of Provider / Person / Facility Address

____________________ ____________________
City, State, Zip Code Phone #/Fax # (include area code)

TYPE OF RECORDS / INFORMATION REQUESTED: ***Check all that apply:***
(Mental health and alcohol/drug treatment records are not included in this authorization unless you complete the following section giving us specific permission to do so).
The records requested may include: ☐ Mental Health Treatment Records ☐ Alcohol / Drug Treatment Records

☐ **Inpatient: date(s)** ____________________
(check only one of the following 3 choices if requesting inpatient records)
☐ Entire copy of the inpatient dates specified above
☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
☐ Specific information or reports: ____________________
(Please describe)

☐ **Outpatient/Office visits: date(s)** __________ **and/or Specific illness/injury** __________
(check type of outpatient visit)
☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery ☐ Emergency Department Record ☐ X-ray reports
☐ Laboratory test results ☐ Immunizations ☐ Other ____________________
(Please describe)

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)
☐ This request only
☐ One year from the date of this authorization *OR* __________ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request and for medical records of any **future** treatment of the type described above until: __________ (insert date).

I understand that:
- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed; ***except*** that records protected by Federal Confidentiality Rules 42CFR, Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative ____________________ Date __________

Relationship to Patient *(if Representative)* ____________________

URMC/SH ROI // Revised 8/04 *Distribution:* Original to medical record. Copy to patient as required.
This authorization must be retained for a minimum of six years beyond the validation limits.