New Patient Authorization for Release of Medical & Behavioral Health Information

NAME _____ DATE OF BIRTH _____

This Authorization allows URMC & Affiliates to RECEIVE copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider or Facility _____

Address _____ **City** _____ **State/Zip** _____

Phone#/Fax# (Include Area Code) _____

Purpose for this request: Health Care

Type of Records Requested:

- 2-3 years of pertinent progress notes
- All immunizations
- Medical imaging
- Most recent EKG
- Most recent labwork
- Any/all procedures (e.g., colonoscopy)
- History & physical
- Other_____

Authorization Valid For: (Check one)

▣ 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 is for medical records of any future treatment of the type described above until: _____

I understand that:

- My right to health care 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 the 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.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative:*_____ Date: _____

Relationship to Patient (if requestor is not the patient): _____

*If completing this form electronically, typing your name serves as your signature.