

SH 48SFC 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) _____