URMC Orthopaedics and Rehabilitation

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Authorization for Release of Medical Information

Patient's Name: Date of Birth: Provider's Name:

Address:

City, State, Zip Code:

Patient's phone: ( ) Date of Request: Date Needed:

☐ I authorize Strong Health/URMC to release information to:

Name of Provider or Faculty:

Address:

City, State, Zip Code:

Phone: ( ) Fax: ( )

OR

☐ I authorize Strong Health/URMC to obtain information from:

Name of Provider or Faculty:

Address:

City, State, Zip Code:

Phone: ( ) Fax: ( )

Purpose for Request: (Check one) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other

Type of Records Requested: (Check one) ☐ Inpatient: date(s) ☐ Outpatient: date(s)

Specific information (Select one or more)

☐ Operative report ☐ History and physical ☐ Discharge summary ☐ Laboratory test results

☐ X-ray reports ☐ Physical therapy ☐ Other (Please describe) ____________

☐ Treatment summary (history, physical, laboratory tests, X-ray reports, operative reports, and pathology)

☐ Entire copy of the inpatient / outpatient report checked above

☐ All medical records related to a specific illness or injury

Specify injury: Date(s) of treatment:

Authorization Valid For: (Check one)

☐ This request only

☐ One year from the date of this authorization **OR** until ______________ (date).
(This authorization applies to entire records of the treatment received on or prior to the date below.)

☐ This request and for medical records of any future treatment of the type above until:_________ (date).

I understand that:

1. My right to healthcare treatment is not conditioned on this authorization.
2. I may cancel this authorization at any time by submitting a written request to the address at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization.
3. If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
4. Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
5. There may be a charge for the requested records.
6. **Medical records are faxed in cases of medical necessity only.**

Signature of patient or representative ______________________________ Date: ____________

Relationship to patient (If requester is not the patient) ______________________________