UNIVERSITY of ROCHESTER MEDICAL CENTER

Highland Hospital
Health Information Management Dept
1000 South Avenue, Box 55
Rochester, NY 14620
Phone: (585)341-6766 Fax: (585)341-8493

& Affiliates

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

PLEASE PRINT.

Patient name: _ Date of Birth: _ _ _ _ _ _ _ _ _ _

Address: Patient's phone#: (_____

City/State/Zip: _____

This Authorization allows URMC & Affiliates to: (check one or both)

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

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

_____ _____
Name of Provider/ Person/Facility Address

_____ _____
City, State, Zip Code Phone #/Fax# include area code

PURPOSE FOR THIS REQUEST: ☐ Healthcare or Appointment **(date)**___ _ ☐ Insurance ☐ Other

TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:

The records requested are to include ☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records

(Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)

☐ **Inpatient admission(s)/date(s):**
(Check only one of the following 3 choices if requesting inpatient records)

☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)

☐ Specific information or reports (describe): _____

☐ Other (describe): _____

☐ Outpatient/Office visits--date(s):_____and/or specific illness/injury:_____

(Check type of outpatient visit to be released)

☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery visit ☐ Emergency Department Record

☐ Radiology report(s) ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)

☐ Other (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, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- 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 chemical dependency treatment records protected by Federal Confidentiality Rules 42C R Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- 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) ----------