UR MEDICINE | HIGHLAND HOSPITAL

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1. Fill in your information
2. Fill in who we are sending your paperwork to (Employer, Disability Company, etc.)
3. Include date of surgery and/or type
4. Sign and date

Bariatric and GI Surgery
1000 South Ave Box 95
Rochester, NY 14620
Ph (585)341-0366
Fax (585)341-6544

RR DONNELLEY

HH 48BGI 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: _____

PURPOSE FOR THIS REQUEST: ☐ Disability Insurance/Employer

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 below

☐ **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:

Surgery date(s): _____ **and/or Specific illness/injury:** _____.

Disability Paperwork; Return to work note; Related records as requested
(Please describe)

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for 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.

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 42CFR 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)* _____