Jones Memorial Hospital 191 North Main Street Wellsville, NY 14895

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Form # 164b (4/14)

Patient Name:	Med Rec #:	Date of Birth:

This authorization allows the Record Custodian to:

RECORD CUSTODIAN:	SEND: copies of your record to (or discuss your information with) the provider/person/facility listed below:
Name: **Jones Memorial Hospital**	Name: _____
Address: **191 N. Main Street, PO Box 72**	Address: _____
City, State, Zip: **Wellsville, NY 14895**	City, State, Zip: _____
Phone: **(585) 596-4043**	Phone: _____

The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

- ☐ Immunization record
- ☐ Laboratory results From (date):_____ To (date):_____
- ☐ X-ray films and imaging reports From (date):_____ To (date):_____ Type:_____
- ☐ Entire record From (date):_____ To (date):_____
- ☐ Other: From (date):_____ To (date):_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Method of communication (select one, please note that email and CD copies are not available in all locations and may require a password):

- ☐ Secure email:_____
- ☐ CD Password:_____
- ☐ Mail paper copy (address above)
- ☐ Pick up paper copy (will require identification)
- ☐ Fax number (medical necessity only):_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information. I can contact the Medical Records Department of Jones Memorial Hospital at 585-596-4043.

Signature of Patient or Legal Representative ►	Date:
If Signed by Legal Representative, Relationship to Patient ►	
Signature of Witness►	Date:

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