



48

Complex Care Center
905 Culver Road
Rochester, NY 14609
Phone: 585-276-7900
Fax: 585-288-1381

SH 48HIM MR 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 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) _____

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 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) _____

Revised 10/13

Distribution: Original to medical record. Copy to patient as required.

This authorization must be retained for a minimum of six years beyond the validation limits.

R.R. DONNELLEY