

**SMH 48S-P MR**

**Authorization for Release of Medical Information**

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip Code: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Patient's phone #: ( ) \_\_\_\_\_  
 Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_

<input type="checkbox"/> I authorize Strong Health/URMC to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	OR	<input type="checkbox"/> I authorize Strong Health/URMC to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)
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**PURPOSE FOR THIS 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, as applicable)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Operative report | <input type="checkbox"/> History & physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory test results |
| <input type="checkbox"/> X-ray reports    | <input type="checkbox"/> Physical Therapy   | <input type="checkbox"/> Other: _____      | (Please describe)                                |

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

Entire copy of the inpatient/outpatient record checked above.

All medical records related to a specific illness or injury.

Specify illness/injury \_\_\_\_\_

Date(s) of treatment \_\_\_\_\_

**AUTHORIZATION VALID FOR:** (Check one)

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.
- 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.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

**NOTE: 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) \_\_\_\_\_