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**SH 48REI MR Authorization for Release 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:**  Healthcare or Appointment (date) \_\_\_\_\_  Insurance  Other

**This Authorization allows URMC & Affiliates to:** (check ONE)

- SEND** copies of your record to (or discuss your information with) the provider/person/facility below
- OR**
- 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 or INFORMATION REQUESTED: Check all that apply:**

**Note: Mental health and alcohol/drug treatment records are not included in this authorization unless you specifically complete the following section giving us permission to disclose this information.**

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.
- 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 records protected by Federal Confidentiality Rules 42CR, 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 5/10

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.