UNIVERSITY of ROCHESTER MEDICAL CENTER

& Affiliates

48

Strong Memorial Hospital
Department or Practice _____
601 Elmwood Avenue, Box #: _____
Rochester, NY 14642
Phone: (585) _____ Fax: (585) _____

SH 48 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)* _____

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.