HIM ROI Authorization

5800713 - Authorization for Release of Protected Health Information

Patient Name_____

Date of Birth_____ SSN:_____

Patient Address

_____

_____

Telephone Number _____

I, or my authorized representative, request health information regarding my care and treatment as set forth on this form.

Instructions: If any section is incomplete, this form may be invalid.

Release Information From:	**Release Information To:**
• Facility/Individual: _____	• Facility/Individual: _____
• Address _____	• Address: _____
_____	_____
• Phone: _____	• Phone: _____
• Fax #: _____	• Fax: _____
☐ UHS Site/Provider:_____	☐ UHS Site/Provider:_____

Date information needed by/Appointment Date:_____

☐ I would like to receive my records via my UHS Patient Portal.

I understand:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 5(a). In the event the Health Information described below includes any of these types of information, and I initial the line on the box in item 5(a), I specifically authorize release of such information to the person(s) indicated above.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

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5(a). Description of Information to be Released: _____
Limit by Date(s) of admission or outpatient visit requested _____
Limit by UHS Site or Provider: _____

❑ Abstract *(History, Consults, OPS, Radiology, Lab, Respiratory, Discharge)*
❑ Billing Records
❑ Clinical Records
❑ Consult(s)
❑ Dental Radiographs
❑ Discharge Summary
❑ History and Physical
❑ Laboratory Reports
❑ Medical Records from other Health Care Providers (patient care only)
❑ Occupational Therapy Records
❑ Operative Report(s)
❑ Pathology Report
❑ Physical Therapy Records
❑ Radiology Disk
❑ Radiology Report
❑ Rehab / Conference / Plan of Care
❑ Speech/Language Pathology
❑ Other: _____
_____

(Initial If Requesting)
__ **Genetic Testing**
__ **Alcohol/Drug Treatment**
__ **Neuropsychological Records***
__ **Psychiatric evaluation/record (mental health records)***
__ **HIV Related Information**
Approved by: _____

5(b). For Verbal Discussion:
❑ By initialing here _____ (Initials) I authorize _____ (Name of Individual) to discuss the following:
❑ Health information with the person(s) listed here: _____ (Name and Relationship).
❑ Billing/Collection information with the person(s) listed here**: _____ (Name and Relationship).

5(c). For Document Pickup Other than by Patients: _____
❑ Pick up prescriptions _____ (Name and Relationship)
❑ Pick up x-rays _____ (Name and Relationship)

5(d). By initialing here _____ I authorize appointment reminders to be left at the following phone number(s): _____.
By initialing here _____ I authorize that a detailed message can be left at the following phone number(s): _____.

6. Reason for Release of Information:
❑ At request of individual ❑ Other: _____

7. Date or event on which this authorization will expire: _____(If not completed, will expire in 365 days)

Signature of Patient (or Qualified Requestor):
_____ Date: _____ Time: _____

If not Patient, Name of Person Signing Form: (Qualified Requestor)
_____

Relationship to Patient (Authority to sign on behalf of patient):
_____

For Internal Use Only: _____ (Print/Signature of person completing request) _____ (Date) _____ (Time)

Sign upon receipt of record, or completion of record release.

* Information from Mental Health Clinical Records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

** If checked copy must be forwarded to UHS Business Office and Patient Accounting

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HOW TO Get Authorization to Send or Receive Health Information at UHS

Please use the form attached: Form 5800713 Authorization for Release of Protected Health Information. To properly complete this form, fill out all sections.

Complete patient demographic information section, including patient name, date of birth, social security number, patient address, and telephone number. If patient doesn't wish to complete the social security number that is ok.

For **"Release Information From"**: Complete the name and address that you want to **release** the protected health information to. If UHS is releasing (sending) information to someone else, check UHS here. If UHS needs information from another facility, for example Lourdes, we would write Lourdes Hospital and Lourdes' address in release from. Simply put, this is the healthcare organization that the information is **coming from.**

For **"Release Information To"**: Complete the name, address and phone number of the **receiving** organization. For example, if we are sending the information to Albany Medical, please put the name, address, physician/department/person and phone number of where you need the information to go. If you want to include the fax number, that can go there as well. We cannot process requests with just a fax number. Simply put, this is the place that the information is **going to.**

For "Date Information Needed by": Put in the date the information is needed by or the Appointment date. This helps us prioritize the requests. If it is for a second opinion while the patient is in the hospital, put STAT, here. Otherwise most of the inpatient requests for appointments will be processed after discharge.

For number 5 (a): Complete the dates of admission or outpatient visits along with UHS Site or UHS Physician, to specify the information that you would like released. This helps ensure that we aren't releasing more information than you want to provide to the receiving location. Check "x" and/or initial any or all boxes that apply to your request in 5 (a). For the third column initials are needed to authorize release for sensitive information, including HIV, Alcohol and Drug treatment, Psychosocial, Genetic Testing and Neuropsych records.

For number 5 (b): Complete the initial line and the name of individual(s) you wish to have PHI discussed with or billing/collection information shared with. Check appropriate boxes and list individual here.

For number 5 (c): If you want to allow others to pick up your information, check the appropriate boxes and fill out the individual(s) you want to allow to pick up that information.

For number 5 (d): Initialing and adding phone numbers near either appointment reminders or detailed messages will allow office to provide information to you or second party.

For number 6: Reason for request can be "x" for At request of a designated individual or Other. Other reasons would include continuity of care, pending transfer to another facility, or second opinion.

For number 7: Complete the date or event the authorization expires in line provided unless patient wishes to keep the release good for a year from the date it was signed.
To complete the request patient or requestor must sign and date to be processed. All forms upon completion should be returned to the Health Information Management Department. If this is a STAT request, for a patient that is being transferred, please bring the chart to Correspondence if we need it to copy for the release, or fax the release and call to ensure that it is completed timely. Correspondence will notify the floor if fax fails to send.