ELIZABETHTOWN COMMUNITY HOSPITAL
75 Park Street
Elizabethtown, NY 12932
518-873-6377

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Please complete as much information as possible

Section A: Must be completed for all authorizations

I authorize the use or disclosure of my health information as described below, which may include:

1. psychological or psychiatric impairment,
2. drug use and/or alcoholism
3. Acquired Immunodeficiency Syndrome (AIDS) -**requires completion of NYS authorization form**; and
4. test for or infection with Human Immunodeficiency Virus (HIV) -**requires completion of NYS authorization form.**

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name_____ DOB_____ MR#_____

Persons/organizations providing the information: Persons/organizations receiving the information:

_____ _____
_____ _____
_____ _____
_____ _____

Specific description of information (including date(s) if known): _____
_____

1.What is the purpose of the disclosure? (not required if requested by patient):_____
_____ _____

Section B: Must be completed if ECH is requesting authorization for uses other than TPO:

2. Will ECH receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____

3. The patient or patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials_____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials_____

_____

Section C: Must be completed for all authorizations

4. I understand that I may revoke this authorization by notifying Elizabethtown Community Hospital in writing at any time, except to the extent that action has been taken in reliance on this authorization.
5. This authorization expires_____ (Insert date or applicable event).

_____ _____
Signature of Patient or Patient's Representative Date
(Form MUST be completed before signing)

_____
Witness

_____
Patient Name

_____
MD Signature

_____ _____
Print Name of Personal Representative (if applicable) Relationship to patient

(A copy of this form will be provided to the patient if authorization requested by ECH)