UPMC LIFE CHANGING MEDICINE

DOH-5032 (12/26/16)
INT 1405*
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NEW YORK STATE DOH AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (INCLUDING ALCOHOL/DRUG TREATMENT AND MENTAL HEALTH INFORMATION) AND CONFIDENTIAL HIV/AIDS-RELATED INFORMATION.

I authorize UPMC Chautauqua to release information from the record of:

_____ _____ _____ _____ as described below to:
Patient Name **Birth Date** **Last 4 digits SSN**

_____ _____ _____
Facility/Person to Receive Records **Phone** **FAX**

Mailing address of facility or person to whom records are to be released, or email address if electronic delivery is preferred

_____ _____ _____ _____
Street **City** **State** **Zip Code**

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(*Please check one):* ☐ Other: _____ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐Paper ☐ CD ☐ FAX (Providers Only) _____ _____ ☐ Other:_____
Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only) *(fax number):* _____
☐ Email: _____ ☐ Direct Address:_____

C. Parts 1 and 2 below must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (check all that apply):

☐ Inpatient – Dates: _____ ☐ Emergency Dept- Dates: _____ ☐ Physician Office/Clinic
☐ Same Day Surgery – Dates: _____ ☐ Outpatient – Dates: _____ ☐ Other _____

2. Specific information to be released (check all that apply): **** For Radiology Images, please contact Department where test was performed***

☐ Abstract (H&P, Consult, Test Results, Discharge Summary)

☐ Allergies	☐ Emergency Department Report	☐ Operative Report	☐ Problem List
☐ Consultation Report	☐ History & Physical Exam	☐ Pathology Report	☐ Procedure List
☐ Diagnostic Tests (cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology)		☐ Physician Office/Clinic	☐ Psych Evaluation
☐ Discharge Instructions	☐ Laboratory Report/Test	☐ Physician Orders	☐ Radiology Report*
☐ Discharge Summary	☐ Medication Administration Records	☐ Physician Progress Notes	☐ Rehabilitation Records
☐ EKG Report	☐ Nurses Notes		

☐ Other, specify: _____
_____

☐ Unless previously revoked by me, the specific information above may be disclosed from :_____ until _____
Date Expiration Date or Event

For the following to be included, indicate the specific
Information to be disclosed and initial below: Information to be disclosed Initials

☐ Records from alcohol/drug treatment programs _____

☐ Clinical records from mental health programs _____

☐ HIV/AIDS-related information _____

All items on this form have been completed and my questions about this form have been answered.

_____ _____ _____
Signature of Patient or Representative Authorized by Law Date Time

Witness Statement/Signature: I have witnessed the execution of his authorization

_____ _____ _____
Staff Persons name and Title Date Time

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: 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.

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Authorization for Release of Protected Health Information

Additional Patient Rights and Responsibilities

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

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 above. In the event the health information includes any of these types of information, and I initial on the line , I specifically authorize release of such information to the person(s) indicated.

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.