AUTHORIZATION FOR RELEASE OF INFORMATION

☐ **Garnet Health Medical Center**
707 East Main Street
Middletown, NY 10940
P: 845-333-1600; F: 845-333-1573
HIM@garnethealth.org

☐ **Garnet Health Medical Center-Catskills**
68 Harris-Bushville Rd., P.O. Box 800
Harris, NY 12742
P: 845-333-8600; F: 845-333-6987
HIM-Catskill@garnethealth.org

☐ **Garnet Health Urgent Care**
Location:
☐ Goshen (845) 333-7200 Fax 845-333-1209
☐ Middletown (845) 333-7575 Fax 845-333-1209
☐ Monticello (845) 333-8600 Fax 845-333-6942

☐ **Garnet Health Doctors - Name of Specialty:** _____
Location:
Fax 845-333-1209 ☐ Goshen (845) 333-7200 ☐ Middletown (845) 333-7575 ☐ Monroe (845) 333-7830
Fax 845-333-6942 ☐ Harris (845) 333-8600 ☐ Monticello (845) 333-8600

I hereby authorize the access, use or disclosure of health information from my medical record as described below. This may include **medical**, **psychological, neuro-psychological, psychiatric, HIV/AIDS test results or diagnoses, drug and/or alcohol abuse** information*. This authorization may include medical records from all Garnet Health locations.

Patient Name:	**Today's Date**:____/__ /20___

Method of Delivery: ☐ Paper (☐ *Mail or* ☐ *Pick up*) ☐ CD ☐ MyChart ☐ Email download

Date of Birth:	**Phone Number:**	**Email Address:**

Mailing Address:

Street *City/ Town* *State* *Zip Code*

Date(s) of service requested: _____

Information that may be disclosed:

☐ Abstract of the Medical Record (Facesheet, Discharge Summary, History & Physical, Consults, Test Results, Procedure Reports, ED Visit)
☐ Entire Medical Record ☐ ED Visit
☐ Laboratory Results ☐ Testing results (radiology, cardiology, etc.)
☐ Office Visit ☐ Urgent Care Visit

☐ Other (specify):_____

***If the requested portion of the record contains information related to drug/alcohol, mental health or HIV related information, you must specifically consent to the release of such information by initialing here_____(must initial).**

Contact information of Person(s)/Organization receiving the information: ☐ Check if for patient listed above

Name:	**Address:**	**City, State, Zip:**
Phone #:	**Fax #:**	**Email:**

1. Reason for release of information:
☐ At the request of individual ☐ Other _____

2. I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

   a. I have the right to revoke this Authorization at any time by writing to the health care provider checked above. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.
   b. Signing this Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
   c. If the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, if I am authorizing the release of substance abuse treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
   d. Garnet Health will not be held responsible for disclosure of PHI while in transmission, or for the safeguarding of the information once delivered, pursuant to my request(s) to receive PHI by email.

3. This authorization expires on_____/____/____. **IF NOT DATED, THE AUTHORIZATION WILL EXPIRE IN ONE YEAR**.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient