

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Name of Patient:\* \_\_\_\_\_  
Address: \_\_\_\_\_  
City / State / Zip \_\_\_\_\_

Soc. Security #: \_\_\_\_\_\*  
Phone Number: \_\_\_\_\_  
Date of Birth:\* \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**1. Type of Request: I hereby request that:**



South Nassau Communities Hospital  
Attn: Medical Records Department/Correspondence  
One Healthy Way  
Oceanside, NY 11572  
Phone: 516-632-4522  
Fax: 516-336-2952

**Provide the following PHI and process it thru:**



IOD  
PO BOX 19058  
Green Bay, WI 54307-9058  
Phone number 516-632-4523  
Fax # 516-336-2952.

**SNCH Internal Use Only**

SNCH MR# \_\_\_\_\_  
ROI # \_\_\_\_\_

or any other such person as they may authorize, and permit them to examine, copy or reproduce, in any manner, any and all portions desired by them of the following:

**2. Include PHI Date Range to be Released (include date range of discharge, service, etc.)** \_\_\_\_\_

**3. Reason for Release:**  Personal Copy,  Continuing Care,  Insurance purposes **4. Select delivery method:**  US Mail (paper copy),  CD of records

**5. Description of PHI to be released: (Check ALL that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abstract/Summary           | <input type="checkbox"/> Mammography             | <input type="checkbox"/> Radiology Reports            |
| <input type="checkbox"/> Ambulatory Surgery         | <input type="checkbox"/> Mental Health Treatment | <input type="checkbox"/> HIV/AIDS Related Information |
| <input type="checkbox"/> Bone Density               | <input type="checkbox"/> Operative Report        | <input type="checkbox"/> Other (Specify) _____        |
| <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Outpatient Visit        |   |
| <input type="checkbox"/> Complete Record            | <input type="checkbox"/> Pathology report/slides |   |
| <input type="checkbox"/> Consultation Reports       | <input type="checkbox"/> Photographs, Videotapes |   |
| <input type="checkbox"/> Diagnostic Testing Results | <input type="checkbox"/> Progress notes          |   |
| <input type="checkbox"/> Discharge Summary          | <input type="checkbox"/> Radiation               |   |
| <input type="checkbox"/> Emergency Room Record      | <input type="checkbox"/> Radiology Notes         |   |
| <input type="checkbox"/> History and Physical       |  |   |
| <input type="checkbox"/> Inpatient Hospitalization  |  |   |

This authorization may include disclosure of information relating to ALCOHOL, and DRUG ABUSE, MENTAL HEALTH TREATMENT except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line below. I specifically authorized release of such information to the person(s) indicated in item 5.

**Include: (indicate by initialing)** \_\_\_\_\_ Alcohol/Drug Treatment \_\_\_\_\_ Mental Health Information \_\_\_\_\_ HIV-Related Information

**5. I authorize SNCH to Release PHI to the following Recipient: (Choose one)**

- Myself (the patient or guardian)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_
- Other/Doctor (be sure to give a complete address)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_

**THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORD UNLESS OTHERWISE NOTED\* FEE: \$0.75 PER PAGE and Fulfillment Fee (Actual Postage) – No Charge if records sent to physician.**

\*This authorization is applicable to patient with drug or alcohol related diagnosis, in which Title 42, Part o2 of the Code of Federal Regulations and/or the New York State Mental Hygiene Law, governs this request. My medical records may contain genetic testing information including test results. Treatment and payment will not be conditional on whether I provide authorization for any requested disclosure by SNCH

\*This authorization may be revoked by written notification from the undersigned to the Health Information Management Department or applicable offsite location.

**• This authorization is effective until (check a date or event):**

\_\_\_\_\_ 6 months \_\_\_\_\_ One year \_\_\_\_\_ Other(Specify time period or event) \_\_\_\_\_

*I certify that I have read, signed and received a copy of this authorization upon my request*

\_\_\_\_\_  
**Signature of patient or personal representative e.g. legal guardian**

\_\_\_\_\_  
**Relationship to patient**

\_\_\_\_\_  
**Print Name if other than Patient**

\_\_\_\_\_  
**Date**

**\*Please allow 10 business days for the processing of your request. All status inquires must be made to IOD using the above contact information number**

- Select payment method: (No Cash Payments)  
 Check (Make Checks out to IOD)  
 Credit Card  
 Money Order