

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Patient:* _____ Soc. Security #:* _____
 Address: _____ Phone Number: _____
 City / State / Zip _____ Date of Birth:* _____ / _____ / _____

1. Type of Request: I hereby request that: _____ Provide the following PHI and process it thru: _____



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



12800 Middlebrook Road, Suite 400
 Germantown, MD 20874
 Phone: 301-916-4700
 Toll Free: 866-683-4700, ext 392
 Fax: 301-916-8776
www.universata.com

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 Transfer to New Doctor Move Attorney/Legal Insurance
4. Select delivery method: eDelivery (secure web link) eFax US Mail Certified Overnight delivery (extra charge)
5. Description of PHI to be Released: (Check ALL that apply)

<input type="checkbox"/> Ambulatory Surgery <input type="checkbox"/> Abstract/Summary <input type="checkbox"/> Bone Density <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Complete Record <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Diagnostic Testing Results <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> History and Physical <input type="checkbox"/> HIV/AIDS Related Information <input type="checkbox"/> Inpatient Hospitalization <input type="checkbox"/> Laboratory Tests <input type="checkbox"/> Mammography Date: _____ <input type="checkbox"/> Mental Health Treatment: _____ <input type="checkbox"/> Operative Report <input type="checkbox"/> Outpatient Visit <input type="checkbox"/> Pathology report/slides; Date: _____	<input type="checkbox"/> Photographs, Videotapes <input type="checkbox"/> Progress notes <input type="checkbox"/> Radiation <input type="checkbox"/> Radiology Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other (Specify) _____
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5. I authorize SNCH to Release PHI to the following Recipient. (AN INVOICE / BILL WILL BE SENT FOR EACH RECIPIENT REQUEST)

Myself (the patient or guardian) Other/Doctor (be sure to give a complete address)

Name: _____ Name: _____
 Address: _____ Address: _____
 E-mail:* _____ E-mail: _____

**** FOR SPEEDY DELIVERY OF YOUR MEDICAL RECORD, PLEASE PROVIDE AN E-MAIL ADDRESS**

6. Responsible Entity to be Billed for Medical Record Information: PLEASE FILL OUT COMPLETELY

Myself (the patient or guardian) Other

Name: * _____ Name: _____
 Address: _____ Address: _____

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).

- 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 will expire after one year of date of authorization***

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 then Patient Date