AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Patient:*_____ Social Security # (Last 4 digits only) :_____
Address:_____ Phone Number:_____
City/State/Zip_____ Date of Birth:_____
Email:_____

1. I hereby request South Nassau Communities Hospital and its Affiliates to provide the following information:

☐	Abstract/Summary of Medical Record *(includes: H&P, Discharge Summary, Diagnostic Results, Medication Ordered/given, operative reports)*		
☐	Emergency Room Record	☐	History and Physical
☐	Discharge Summary	☐	Operative Reports
☐	Consultation Report(s)	☐	Discharge Plan and/or Instructions**
☐	Entire Medical Record	☐	Radiology Films & CD's
☐	Diagnostic Testing: Radiology	☐	Pathology/Lab Slides
☐	Diagnostic Testing: Lab	☐	Other (Specify):
☐	Diagnostic Testing: Pathology	☐	

2. Date Range of PHI to be released: _____

Reason for Release:	Personal Copy: □	Continued Care: □	Insurance: □	**Designated direct care giver: □

This authorization may include disclosure of information relating to ALCOHOL, and DRUG ABUSE, MENTAL HEATLH TREATMENT except psy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line below. I specifically authorize release of such information to the person(s) indicated in item 3 below.
Include: (indicate by initialing) _____Alcohol/Drug Treatment _____Mental Health Information _____HIV-Related Information

3. I authorize SNCH and Affiliates to Release PHI to the following Recipient(s):

Myself (the patient or guardian)	**Other/Doctor**	****Designated Care Giver:**
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
City/State/Zip Code: _____	City/State/Zip Code: _____	City/State/Zip Code: _____
_____	Phone#: _____	Phone#: _____

THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORD UNLESS OTHERWISE NOTED ***FEE: $0.39 per page for CD or Paper Copy, $0.36 per page for Patient Portal and Fulfillment Fee (Actual Postage) – No Charge if records sent to physician.***

This authorization is applicable to patients with drug or alcohol related diagnosis, in which Title 42, Part 2 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.
****For Designated Care Giver, Information to be released only includes all medical information contained in the discharge plan and discharge instructions.***

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 Relationship to patient Print Name (if other than patient)

Date: _____

Please allow up to 7 business days for the processing of your request. Your record is being processed by CIOX HEALTH

Internal Use: MR#_____ ROI#_____
Payment Method(No Cash Payment) ____ Credit Card ____Money Order _____Check (Make check payable to CIOX)

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