CMH
Columbia Memorial Health
An affiliate of ALBANY MED

AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION

AUTH-REL-INFO

Columbia Memorial Hospital, Columbia Memorial Family care, Columbia Memorial Specialty Clinics

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patients have the right to inspect and obtain a copy of most information in our records that may be used to make decisions about them or their treatment for as long as we maintain the information in our records. Patients may also authorize the use or disclosure of the records and protected health information contained in the records. Please see our Notice of Privacy Practices for a more detailed description of these rights and the process we follow once we have received a request or authorization. To request access, or a copy of, your medical records, or to authorize the use or disclosure, please complete and return this form.*

***"We", "our" and similar terms include each of the organizations listed above, and affiliated organizations; this is more fully described in our Notice of Privacy Practices.**

PATIENT INFORMATION

Patient Name: _____
Last First M.I.

Address: _____ DOB: _____

_____ Telephone: _____ Email: _____

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____ Email: _____

REASON FOR RELEASE OF INFORMATION

Check all that apply:

- ☐ At request of Patient
- ☐ Legal purposes - e.g. Attorneys
- ☐ Insurance - e.g. life insurance application
- ☐ Continuing Care - e.g. Other Healthcare Providers, Hospital, Physicians
- ☐ Other _____

INFORMATION TO BE RELEASED

Information that will be used or disclosed. If you can, please provide the dates that tests were performed or treatment was provided.
Check all that apply.

Type of Record	Name of Physician, Procedure or other Identifier	Date of Service or Description
☐ Medical records relating to		
☐ Emergency department record		
☐ Physician office note(s)		
☐ Billing records		
☐ Consultation report		
☐ History and physical		
☐ Diagnosis/treatment relating to		
☐ Operative report		
☐ Discharge summary		
☐ Entire medical record		
☐ Other		

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* A U T H – R E L – I N F O *

Type of access you request. Check all that apply:

INSPECT _____ COPY _____

If your request to inspect the information is granted, we will provide you with further information on how to schedule an appointment with our staff to inspect your records.

If you are requesting a copy of the information, how would you like these materials delivered to you and in what format?

Check one Delivery Type: ○ PICKUP ○ BY MAIL ○ BY FAX ○ BY EMAIL
Check One format if Applicable ○ PAPER ○ CD ROM

If your request is being made because of an emergency, please describe the nature of the emergency and the date you need the information. We cannot guarantee that we will meet your deadline, but we will attempt to accommodate reasonable requests.

_____

_____

FEES

Copying. We will charge you a reasonable fee to recover the costs of copying, mailing, and the supplies used to fulfill your request. Our standard fee for copying is currently $0.75 per page and capped at $6.50 for electronic media.

PATIENT UNDERSTANDING AND SIGNATURE

I authorize Columbia Memorial (including each of the entities described above) to release (disclose) information in the manner described above. I have the right to revoke this authorization at any time by sending my written revocation to (see address below). I understand that the revocation will not apply to any information released prior to your receipt of my written notice and a reasonable period in which to react to it. I understand that completion of this form is not a condition to treatment. Any information used or disclosed under this authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving or using it.

I understand that the information released may include confidential records regarding psychological or psychiatric conditions or treatment, drug use and / or alcoholism, confidential HIV information as defined by law, including without limitation information regarding treatment of Acquired Immunodeficiency Syndrome (AIDS) or associated conditions, and / or test orders or results relative to HIV infection. HIV / AIDS records may be protected under state or federal law and, except as otherwise provided by law, cannot be disclosed without my written consent which I may revoke at any time and by any reasonable means of communication.

This Authorization will expire ninety (90) days from the date I sign unless a longer period is indicated here_____ . I acknowledge that I have received a completely filled in copy of this Authorization after I signed it.

SEND COMPLETED FORM
TO:

_____
Signature of Patient or Legally Authorized (Personal) Representative

_____
Print Name of Patient or Legally Authorized (Personal) Representative

Date _____

_____
Description of Authority or Legally Authorized (Personal) Representative

Columbia Memorial Hospital
71 Prospect Ave Hudson NY 12534
Fax 518-828-8520

For CMH USE only:

Date Received: (MO/DY/YR) ____ / ____ / ____

Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED

Patient Notified in Writing Of Response On This Date: (MO/DY/YR) ____ / ____ / ____

Fee Charged For Fulfilling This Request (if applicable): $ _____

Name or Initials of Staff Member Processing This Request: _____