

ROME MEMORIAL HOSPITAL

1500 North James Street, Rome, New York 13440
(315) 338-7133

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
Last, First Middle Birthdate Age

ADDRESS: _____
Street City State Zip Code Phone

The above named patient hereby authorizes and requests _____ to provide:

NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

FOR THE PURPOSE: _____

Information to be released: _____

Which may be inclusive of the history, diagnostic and therapeutic information including **PSYCHIATRIC CARE AND ANY TREATMENT FOR ALCOHOL AND DRUG ABUSE.**

EXCEPTION to information released: _____

DATE (S) OF SERVICE: _____ through _____

This authorization shall be in effect for:

365 days after the date of signature

or

Date of Expiration

or

The happening of the following expiration event:

at which time this authorization to use or disclose this protected health information expires.

I understand that, as set forth in the hospital's Notice of Privacy practices, I have the right to revoke this authorization in writing, at any time by sending written notification to:

Rome Memorial Hospital
1500 North James Street
Rome, New York 13440

ATTN: Privacy Officer

- I understand that a revocation is not effective to the extent that the hospital has relied on the use or disclosure of the protected health information.
- * I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the hospital will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

Signed: _____
(Patient)

(Date)

OR _____
(Personal Representative)

(Relationship to Patient)

(Witness)

This authorization must be signed by the patient. If the patient is under 18 or is physically unable, the authorization is to be signed by the nearest relative. In cases of mental incompetence, the legal guardian must sign.