UR Medicine
Health Information Management (HIM) Department
601 Elmwood Avenue, Box 616 • Rochester, NY 14642-8616
Phone: (585) 275-2605 • Fax: (585) 273-1257 or (585) 424-2922

SH 48 AUTHORIZATION FOR RELEASE / DISCLOSURE OF MEDICAL AND/OR BEHAVIORAL HEALTH INFORMATION

Patient's name (print): _____ Date of Birth: _____

Address: _____

City, State & Zip Code: _____

Patient's daytime phone (_____) _____

This Authorization allows UR Medicine to (*check all that apply*):

☐ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

☐ **RECEIVE** copies of your record to (or discuss your information with) the provider/person/facility below

Name of Provider/Person/Facility: _____

Address: _____

City, State & Zip Code: _____

Phone #: (_____) _____ Fax #: (_____) _____

Purpose for this request: ☐ Health care or appointment on DATE: _____ ☐ Insurance ☐ Other

Type of records or information requested (*check all that apply*):

☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records

☐ FF Thompson Hospital ☐ Highland Hospital ☐ Jones Memorial Hospital ☐ Nicholas Noyes Hospital

☐ St. James Hospital ☐ Strong Memorial Hospital

Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2554 or OCA 960

☐ Inpatient Admission(s)/date(s) – check ONE of the following three choices if requesting inpatient records:

- ☐ Treatment Summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
- ☐ Specific information or reports (describe): _____
- ☐ Other (describe): _____

☐ Outpatient/Office visits: DATE(S): _____ and/or specific illness/injury: _____

Check type of outpatient visit to be released:

- ☐ Clinic/doctor/dental visit ☐ Ambulatory surgery visit ☐ Emergency Dept. record ☐ Radiology report(s)
- ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)
- ☐ Other (describe): _____

AUTHORIZATION VALID FOR: (if no selection is made, this authorization is valid for this request only)

☐ This request only

☐ One year from the date of this authorization OR (insert date): _____ – this authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for records of any **future** treatment of the type described above until (insert date): _____

I understand that:

- My right to health care treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my insurance provider.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed, except that chemical dependency treatments records protected by Federal Confidentiality Rules 42C R Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if signing as authorized representative): _____