MR # DOB

NAME

DATE

Medical Record Number _____
For Office Use Only

BASSETT HEALTHCARE NETWORK
☐ **BASSETT MEDICAL CENTER**
Cooperstown, NY 13326
☐ **COBLESKILL REGIONAL HOSPITAL**
Cobleskill, NY 12043
☐ **LITTLE FALLS HOSPITAL**
Little Falls, NY 13365
☐ **O'CONNOR HOSPITAL**
Delhi, NY 13753
☐ **TRI-TOWN REGIONAL HOSPITAL**
Sidney, NY 13838
☐ **Clinic** _____

AUTHORIZATION FOR MEDICAL RECORD RELEASE

H-6653 5/03;3/04;2/05;7/06;3/12 (d:\forms\hosp\.ofm)

Patient Name | Date of Birth | Phone Number

Address | City, State | Zip

Please check one:
Purpose: ☐ Medical Treatment ☐ Disability ☐ Insurance ☐ Legal Reasons ☐ Personal
Upcoming appointment date: _____

Name and address of Person/ Institution Releasing Information: _____

Name and address of Person/ Institution Receiving Information: _____

Extent of Information To Be Released (Include dates, providers etc.) _____

Please do not disclose the following: ☐ **HIV-related information** ☐ **Genetic Testing**
☐ **Alcohol & Drugs** ☐ **Psychological or Psychiatric** ☐ **Pregnancy**

Release Valid From:_____ to _____ (If blank one year from signature date)

The releasing provider listed above is hereby authorized to release information from the medical records of the above named patient. This authorization permits release of information to include information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV-related test, HIV infection, HIV-related illness, AIDS or any information which could indicate potential exposure to HIV, and any information related to or regarding genetic testing.

I understand that Bassett Healthcare Network will not condition treatment on my providing authorization for disclosure. I further understand that I do not have to allow the release of this information in part or entirety. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Bassett Healthcare Network, Release of Information, or the site releasing the records. I understand that a revocation will not apply to information that has already been released.

I understand that the information to be released from the medical record is confidential and will not be released except to the person/institution named below. I acknowledge that any disclosure to a third party can lead to unauthorized re-disclosure by that person or others, which may not be subject to federal or state confidentiality laws. I also understand that a fee of $0.75 per page may be charged to the requestor for copying records.

_____/_____ _____
Signature of patient, parent or legal guardian (relationship) Date

_____/_____ _____
Signature of witness Date Address of witness

TO BE COMPLETED BY BASSETT MEDICAL CENTER PERSONNEL ONLY

RELEASE	REQUEST
Validation of Requestor's Identity _____ (Please note what form of ID was presented)	Request Sent By _____
Number of Pages Copied _____ Date _____	Date _____
Completed by _____	Department _____
	Sent Via ☐ Fax ☐ Mail

RELEASE OF INFORMATION Request

White Copy - Chart Yellow Copy - Patient