MR #

DOB

NAME

DATE

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BASSETT HEALTHCARE NETWORK
☐ **A.O. FOX HOSPITAL**
Oneonta, NY 13820
☐ **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

Medical Record Number _____
For Office Use Only

☐ **Clinic** _____

AUTHORIZATION FOR MEDICAL RECORD RELEASE

H-6653 5/03;3/04;2/05;7/06;3/12;4/16;9/17;2/18;7/25 (d:\forms\hosp\.ofm)

1. PATIENT INFORMATION:

Full Name – Last, Frist, MI _____ Former Names/Aliases _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____ Birthdate _____ Phone _____

2. RECORDS TO BE SENT TO:

□ Self, address listed above

Name _____ Phone _____ Fax _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____

3. AUTHORIZATION FOR VERBAL COMMUNICATION:

I am authorizing Bassett Healthcare Network to discuss my health information with_____. Authorization for verbal communication is valid until _____. I may revoke this authorization for verbal communication at any time by contacting the Bassett Healthcare Network.

4. DISCLOSURE FORMAT: If left blank, information will be provided through MyBassett Portal

□ **MyBassett Portal** □ **USB** □ **CD** □ **Fax**_____
□ **Paper – US Mail** □ **Paper Pick up Maple Ridge** □ **Paper Pick up A.O. Fox**
□ **Email:** _____

Email requests are sent through secure (encrypted) delivery unless otherwise directed. Unencrypted email poses privacy risks. Bassett is not responsible for unauthorized access to unencrypted email containing confidential information. By checking box, I request, acknowledge, and accept risk associated to sending unencrypted email. □ **Unencrypted Email.**

5. RECORDS TO BE DISCLOSED:

Date Range: From: _____ To: _____ If left blank, information from the past (1) year will be provided.

□ Emergency Report □ Discharge Summary □ History & Physical □ Radiology Images
□ Operative Report □ Consultation Report □ Laboratory/Pathology □ Radiology Report
□ Clinic Notes □ Billing Records □ Cardiac Studies/EKG □ Behavioral Health
□ Pertinent Records (Discharge Summary, History & Physical, Operative Report, Emergency Report & Consultation)
□ Entire Medical Record
□ Other: _____

6. I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by state and federal law)

□ Alcohol/Drug/Substance Use Disorder Treatment □ HIV related information
□ Psychological / Psychiatric Treatment □ Genetic Testing

7. PURPOSE OF REQUEST:

□ Patient Request □ Continuing Care □ Insurance □ FMLA/Disability
□ Legal/Attorney □ Other: _____

8. EXPIRATION OF RECORD DISCLOUSRE:

This authorization is in effect until _____(date/event). If left blank, authorization for record disclosure will expire (1) year from the date signed.

9. YOUR RIGHTS & ACKNOWLEDGEMENTS:

- I understand I may revoke this authorization at any time by sending written notification to Bassett Healthcare, Release of Information or the site releasing the records. I understand that revocation will not apply to information that has already been released based upon this authorization.
- I understand information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal or state law.
- If I am authorizing the release of alcohol and drug treatment, mental health treatment, and/or confidential HIV/AIDS related information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the NY State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
- I understand that Bassett Healthcare may not refuse treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the treatment provided is to be solely for the purpose of creating protected health information for disclosure to the party listed in the authorization.
- Signing this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

10. SIGNATURE:

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

If signed by a person other than the patient, indicate relationship:

Individual is: □ a minor (treatment exception) □ legally incompetent or incapacitated □ deceased
Legal authority: □ parent □ legal guardian □ activated POA for Health Care
□ next of kin/executor of deceased □ other: _____

NOTICE TO RECIPIENT: 42 CFR part 2 prohibits unauthorized use or disclosure of these records.