THE University of Vermont HEALTH NETWORK

**Elizabethtown Community Hospital**

| Elizabethtown Campus | Ticonderoga Campus |
|---|---|
| 75 Park Street | 101 Adirondack Dr, Ste 1 |
| Elizabethtown, NY 12932 | Ticonderoga, NY 12883 |

MRN

Name

DOB

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**BY SIGNING THIS FORM, YOU AUTHORIZE ELIZABETHTOWN COMMUNITY HOSPITAL OR ITS AGENTS TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES IN SECTION C BELOW. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.**

**Section A:**

**Patient Name:**______________________________________________________________ **Date of Birth:**______________________

**Patient Address:**_____________________________________________________________**City:** ______________________________

**State & Zip Code:**_______________________________________**Phone Number:** __________________________________________

**Section B: Reason for Release of Information:**

| ☐ Medical Care | ☐ Personal Records | ☐ Insurance/ Payment | ☐ Workers' Compensation | ☐ School: |
|---|---|---|---|---|
| ☐ Attorney/Legal Proceedings | ☐ Provider Transfer | ☐ Disability | ☐ Other: | |

**Section C: Party to Receive or Obtain Information:**

☐ Release a copy of my protected health information (PHI) to:

☐ Obtain a copy of my PHI from:

| Name: | |
|---|---|
| Address: | |
| Phone Number: | Fax Number: |

Delivery Method : ☐Mail ☐Pick Up ☐ Secure portal (Please provide email address to receive link:
☐E-mail address: ________________________________________ **(only for patients, patient guardian(s), or next of kin for deceased patients).**

☐ Other: ______________________

**Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.**

**Section D: Description of the Information to be released:**

**The date of service and type(s) of information to be used or disclosed are as follows**:

The records to be released will cover the time period from ___________________________to_________________________

Records from a specific Provider/Clinic: ______________________________________________________________________________

| | | | |
|---|---|---|---|
| ☐ Discharge Summary | ☐ Emergency Dept. Notes | ☐ Cardiology Testing Reports | ☐ Billing |
| ☐ Inpatient Notes | ☐ Laboratory/Pathology Reports | ☐ Radiology Reports | ☐ Immunizations |
| ☐ Office or Clinic Notes | ☐ Operative Reports | ☐ Radiology Images | ☐ History and Physical |
| ☐ Consults | | | |

☐ Other: ______________________________________________________________________________________________

ROI Form #037347 (06/2023)

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**Section E:**

**For certain sensitive information, you must initial in the box below for the information to be included in your release.**

SENSITIVE HEALTH INFORMATION This form authorizes Elizabethtown Community Hospital to release the following types of information, **ONLY IF** you place your initials in the space provided:

________ Mental Health Records (including Psychotherapy) _______Confidential HIV/AIDS Information

________ Sexually Transmitted disease (STI) records _______Genetic Testing Results

________ Substance, Drug, Alcohol Use Disorder Records from a 42 CFR Part 2 program

- Certain alcohol/drug treatment information from a "Part 2 Program" must be accompanied by the required statement regarding prohibition of re-disclosure. (42 CFR Part 2)
- For New York sites: Confidential HIV/AIDS information must be accompanied by the required statements regarding prohibition of disclosure when required by law. Information from certain mental health clinical records may be released pursuant to this authorization to the parties identified, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

**I understand and agree that:**

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management: **Elizabethtown Campus Phone: 518-873-3065 or Fax: 518-873-3067; Ticonderoga Campus Phone: 518-585-3908 or Fax: 518-585-3993.**
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law, unless specific re-disclosure laws apply.
- Signing this form is voluntary. I do not need to sign this form to receive health care services from the organizations, affiliates, or entities within The University of Vermont Health Network.
- **This authorization will expire on __________________________. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.**

**When the patient is a minor or is not competent to provide authorization, the signature of a parent, legal guardian or other legal representative is required. If the patient is between the ages of 12-17, the patient will need to authorize the release of records for some services. Documentation of a legal representative's authority may be required to process this form.**

_____________________________________ ______________ ________________

Signature of Patient Date Time

_____________________________________ ______________ ________________

Signature of Parent or Legal Representative Date Time

_____________________________________ _____________________________________

Print Name Relationship (if signed by Parent/Legal Representative)

| FOR OFFICE USE ONLY | | |
| --- | --- | --- |
| I have authenticated the identity of the person named in this authorization form via ☐Photo ID ☐Other | | |
| **Employee Signature** | **Date Received** | **Date Completed** |

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