HealthAlliance of the Hudson Valley®
YOUR PARTNERS IN HEALTH
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# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____ _____
Patient Name ( First, Middle, Last) Date of Birth / Medical Record Number

_____ _____
Previous Name, if Applicable Phone Number

**INFORMATION MAY BE DISCLOSED BY: ( please check )**
_____ Benedictine Hospital, 105 Marys Ave, Kingston, NY 12401
_____ Kingston Hospital, 396 Broadway, Kingston , NY 12401
_____Margaretville Hospital, 42084 State Highway 28, Margaretville, NY 12455

**INFORMATION MAY BE DISCLOSED TO:**

Name/Organization:_____

Address:_____

Phone#:_____ Fax#:_____

**DATES OF TREATMENT:** _____

**INFORMATION TO BE DISCLOSED: Please check off all requested reports.**

| | | |
|---|---|---|
| ___ History & Physical | ___ Emergency Room Report | ___Op/Procedure Report |
| ___ Discharge Summary | ___ X-Ray & Lab Reports (Pathology) | ___ Other _____ |
| ___ Consultations | ___ Cardiology Services | _____ |

**PURPOSE OF DISCLOSURE:**
_____ Use by another health care provider Other (please describe)_____
_____ Personal Copy ($0.75 per page)

**EXPIRATION DATE:** This authorization will expire (insert date)_____. I understand that if I fail to specify expiration date, this authorization will expire within 90 days from the date on which it was signed for the above information.

**REDISCLOSURE:** I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**SENSITIVE RECORDS:** I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under Federal or State Law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the NYS Division of Human Rights at 212-870-8624. It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

**REVOKING THE AUTHORIZATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____ _____
Date Signature of Patient or Legal Representative Relationship to Patient