

& Affiliates



\*48\*

Strong Memorial Hospital Child Neurology 601 Elmwood Ave • Box 631 Rochester, NY 14642

Phone: (585) 275-2808 Fax: (585) 275-3683

## SH 48NEU MR Authorization for Release of Medical and/or Behavioral Health Information

PLEASE PRINT: Patient name:	Date of Birth:
	Patient's phone#: ( )
City/State/Zip:	
This Authorization allows URMC & Affiliates	to: (check one or both)
SEND copies of your record to (or discuss	your information with) the provider/person/facility below
RECEIVE copies of your record from (or di	iscuss your information with) the provider/person/facility below
	,,,,,,,,,
Name of Provider/ Person/Facility	Address
City, State, Zip Code	Phone #/Fax # (include area code)
Only, chare, Alp Cour	Priorie #Fax # (include area code)
PURPOSE FOR THIS REQUEST: Healthca	re or Appointment (date) \$\sigma\$ Insurance \$\sigma\$ Other
TYPE OF RECORDS or INFORMATION REQUI	ESTED: Check all that apply:
The records requested are to include:   Mental Health To	reatment Records
(Release/disclosure of HIV-related information requires add	<del>-</del>
☐ Inpatient admission(s)/date(s):	· ·
(Check only one of the following 3 choices if requesting inpatie	
<ul> <li>Treatment summary (includes discharge su pathology)</li> </ul>	emmary, history/physical, laboratory tests, x-ray reports, operative reports,
<ul> <li>Specific information or reports (describe).</li> </ul>	
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 Sui	rgery visit    Emergency Department Record
III. Davidos espectos III. Laborator, test consite	El James minetione El Disselectiones (see all the many annual (see
E. Olifer (describe): D13203310 04	ONGOING MANAGEMENT OF HEADACHE IN SCHOOL SET
This request only	icked below, this authorization is valid for this request only.)
M 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.  treatment of the type described above until:(insert date
I understand that:	
circumstances (e.g. non-emergent mental	ditioned on this authorization, except in very limited health or chemical dependency treatment).
<ul> <li>I may cancel this authorization at any time the top of this form, except where a disclosing</li> </ul>	by submitting a <u>written</u> request to the address provided at sure has already been made in reliance on my prior
authorization.	
covered by privacy regulations, the information	nation is not a health care or medical insurance provider ation stated above could be redisclosed, except that
chemical dependency treatment records p	rotected by Federal Confidentiality Rules 42CFR Part 2 may ization unless otherwise provided for in the regulations
<ul> <li>There may be a charge for the requested r</li> </ul>	records.
The medical records requested above may	/ De Taxed In Cases of medical necessity.
Cinceluse of Delicular Description	D-to
Signature of Patient or Representative	Date



& Affiliates



\*48\*

## Strong Memorial Hospital

Child Neurology 601 Elmwood Ave • Box 631

Rochester, NY 14642

Phone: (585) 275-2808 Fax: (585) 275-3683

## SH 48NEU MR Authorization for Release of Medical and/or Behavioral Health Information

Address:	1 000101101101	Date of Birth:	
This Authorization allows URMC & Affiliates to: (check one or both)    SEND   Copies of your record to (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   Address	Address:	Patient's phone#: ( )	
This Authorization allows URMC & Affiliates to: (check one or both)    SEND   Copies of your record to (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE   Copies of your record from (or discuss your information with) the provider/person/facility below   Address	City/State/Zip:		
SEND copies of your record to (or discuss your information with) the provider/person/facility below   RECEIVE copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE copies of your record from (or discuss your information with) the provider/person/facility below   RECEIVE copies of your record from (or discuss your information with) the provider/person/facility below   Address   Phone ##Fax # (include area code)			
Name of Provider/ Person/Facility  Address  City, State, Zip Code  Phone #/Fax # (include area code)  PURPOSE FOR THIS REQUEST:  The records requested are to include:  Mealth-related information requires additional authorization on form NYS DOH2557 or OCA 960)  Inpatient admission(s)/date(s):  (Check only one of the following 3 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):  Outpatient/Office visitsdate(s):  (Check only one of logical wist to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient)  The records of the following a choice of requesting inpatient records)  Check (type of outpatient)  The rearment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)  Specific information or reports (describe):  Check (type of outpatient)  Check (type	This Authorization allows URMC & Affiliates to:	(check one or both)	
Name of Provider/ Person/Facility  Address  City, State, Zip Code  Phone #/Fax # (include area code)  PURPOSE FOR THIS REQUEST:  The records requested are to include:  Mealth-related information requires additional authorization on form NYS DOH2557 or OCA 960)  Inpatient admission(s)/date(s):  (Check only one of the following 3 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):  Outpatient/Office visitsdate(s):  (Check only one of logical wist to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient visit to be released)  Check (type of outpatient)  The records of the following a choice of requesting inpatient records)  Check (type of outpatient)  The rearment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)  Specific information or reports (describe):  Check (type of outpatient)  Check (type	SEND copies of your record to (or discuss your	r information with) the provider/person/facility bel	ow
Name of Provider/ Person/Facility	<b>~</b>	•	
PURPOSE FOR THIS REQUEST:   Healthcare or Appointment (date)   Insurance   Other  TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:  The records requested are to include:   Mental Health Treatment Records   Alcohol/Drug Treatment Records  (Release/disclosure of HilV-related information requires additional authorization on form NYS DOH2557 or OCA 960)    Inpatient admission(s)/date(s):   (Check only one of the following 3 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):   and/or specific illness/injury:   (Check type of outpatient visit to be released)   Clinic/doctor/dental visit   Ambulatory Surgery visit   Emergency Department Record   Radiology report(s)   Laboratory test results   Immunizations   Physical/occupational therapy record(s)   Check type of outpatient visit to be released)   Clinic/doctor/dental visit   Ambulatory Surgery visit   Emergency Department Record   Radiology report(s)   Laboratory test results   Immunizations   Physical/occupational therapy record(s)   This request only   This authorization applies to the records of the treatment records of any future treatment of the type described above until:   (insert date)   Tunderstand that:   This request only   This re	ECEIVE copies of your record from (or discus	ss your information with) the provider/person/facil	lity below
PURPOSE FOR THIS REQUEST:   Healthcare or Appointment (date)   Insurance   Other  TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:  The records requested are to include:   Mental Health Treatment Records   Alcohol/Drug Treatment Records  (Release/disclosure of HilV-related information requires additional authorization on form NYS DOH2557 or OCA 960)    Inpatient admission(s)/date(s):   (Check only one of the following 3 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):   and/or specific illness/injury:   (Check type of outpatient visit to be released)   Clinic/doctor/dental visit   Ambulatory Surgery visit   Emergency Department Record   Radiology report(s)   Laboratory test results   Immunizations   Physical/occupational therapy record(s)   Check type of outpatient visit to be released)   Clinic/doctor/dental visit   Ambulatory Surgery visit   Emergency Department Record   Radiology report(s)   Laboratory test results   Immunizations   Physical/occupational therapy record(s)   This request only   This authorization applies to the records of the treatment records of any future treatment of the type described above until:   (insert date)   Tunderstand that:   This request only   This re	Alexand Davids (D. 1977)		
PURPOSE FOR THIS REQUEST:   Healthcare or Appointment (date)   Insurance   Other  TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:  The records requested are to include:   Mental Health Treatment Records   Alcohol/Drug Treatment Records  (Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)  Inpatient admission(s)/date(s): (Check only one of the following 3 choices if requesting inpatient records)   Inpatient admission(s)/date(s): (Check only one of the following 3 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):   and/or specific illness/linjury:     Outpatient/Office visitsdate(s):   and/or specific illness/linjury:     Check type of outpatient visit to be released)   Chinc/doctor/dental visit   Ambulatory Surgery visit   Emergency Department Record   Radiology report(s)   Laboratory test results   Immunizations   Physical/occupational therapy record(s)     Check type of outpatient visit to be released)   Other (describe):   DISCUSSIONIS   TO COLLABOR ATE ON ONGOWNO MARGEMENT  AUTHORIZATION VALID FOR: (If nothing is checked below, 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, 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 prior 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 prior authorization	•	Address	
TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:  The records requested are to include:   Mental Health Treatment Records   Alcohol/Drug Treatment Records    (Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)  Inpatient admission(s)/date(s):  (Check only one of the following 3 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):	City, State, Zip Code	Phone #/Fax # (include area code)	
TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:  The records requested are to include:   Mental Health Treatment Records	BURDOOF FOR THE REQUEST.		
The records requested are to include:  Mental Health Treatment Records  Alcohol/Drug Treatment Records  (Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)  Inpatient admission(s)/date(s): (Check only one of the following 3 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): Other (describe): Other (describe): Check type of outpatient visit to be released) Clinic/doctor/dental visit   Ambulatory Surgery visit  Emergency Department Record Radiology report(s): Authorization SI Physical/occupational therapy record(s) Check type of outpatient visit to be released) Check describe): Check type of outpatient visit to be released) Check type of outpatient visit to be released only.)  This request only Check type of outpatient visit to be released) Check type of outpatient visit to be address only.)  This request only Check type of outpatient visit to be released) Check type of outpatient visit to be released.  In the real type of the request visit to the	PURPOSE FOR THIS REQUEST:   Healthcare of	r Appointment (date)	e 🛚 Other
Inpatient admission(s)/date(s):	TYPE OF RECORDS or INFORMATION REQUEST	ED: Check all that apply:	
Inpatient admission(s)/date(s):	The records requested are to include:   Mental Health Treatn	nent Records - Fl Alcohol/Drug Treatment Recor	rde
Inpatient admission(s)/date(s):			us
(Check only one of the following 3 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):  Check type of outpatient visit to be released)  Clinic/doctor/dental visit	- to to the state of the state	ar dutionization of form this bolization of GOA 300)	
Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)  □ Specific information or reports (describe): □ Other (describe): □ Outpatient/Office visitsdate(s): □ (Check type of outpatient visit to be released) □ Clinic/doctor/dental visit □ Ambulatory Surgery visit □ Emergency Department Record □ Radiology report(s) □ Laboratory test results □ Immunizations □ Physical/occupational therapy record(s) □ Other (describe): □ DISCUSSIONS TO COLLARIDE ATE ON ONGOING MARCEMENT  AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.) □ This request only □ One year from the date of this authorization OR			
Described information or reports (describe):  □ Other (describe): □ Other (describe): □ Other (describe): □ Other (describe): □ Other (describe): □ Other (describe): □ Clinic/doctor/dental visit to be released) □ Clinic/doctor/dental visit □ Ambulatory Surgery visit □ Emergency Department Record □ Radiology report(s) □ Laboratory test results □ Immunizations □ Physical/occupational therapy record(s) □ Other (describe): DISCUSSIONS TO COLLABINEATE ON ONGOING MANAGEMENT  AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.) □ This request only □ One year from the date of this authorization OR			
Specific information or reports (describe):  Other (describe):  Outpatient/Office visitsdate(s):  (Check type of outpatient visit to be released)  □ Clinic/doctor/dental visit □ Ambulatory Surgery visit □ Emergency Department Record  □ Radiology report(s) □ Laboratory test results □ Immunizations □ Physical/occupational therapy record(s)  □ Other (describe): ∑\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	pathology)	ary, history/physical, laboratory tests, x-ray reports, ope	rative reports.
Outpatient/Office visitsdate(s):and/or specific illness/injury:  (Check type of outpatient visit to be released)  □ Clinic/doctor/dental visit □ Ambulatory Surgery visit □ Emergency Department Record  □ Radiology report(s) □ Laboratory test results □ Immunizations □ Physical/occupational therapy record(s)  □ Other (describe): DISCUSSIONS TO COLLABINE ATE ON ONGOING MANAGEMENT  AUTHORIZATION VALID FOR: (If nothing is checked below, 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 medical records of any future treatment of the type described above until: (insert date).  □ Inderstand that:  □ My right to healthcare 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 prior authorization.  □ 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 treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.  □ The medical records requested above may be faxed in cases of medical necessity.	Specific information or reports (describe):		
Outpatient/Office visits—date(s):	Other (describe):		
Check type of outpatient visit to be released)  Clinic/doctor/dental visit  Ambulatory Surgery visit  Immunizations  Physical/occupational therapy record(s)  Check (describe): DISCUSSIONIS TO COLLABINGATE ON ONGOING MANAGEMENT  AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)  This request only  One year from the date of this authorization OR			
Radiology report(s) Laboratory test results Immunizations Physical/occupational therapy record(s) Other (describe): DISCUSSIONS TO COLLABING ATE ON ONGOING MANAGEMENT AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.) This request only One year from the date of this authorization OR	(Check type of outpatient visit to be released)		•
AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)  This request only  One year from the date of this authorization OR	☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery	visit	
AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)  This request only  One year from the date of this authorization OR	Radiology report(s) Laboratory test results	Immunizations   Physical/occupational thera	py record(s)
This request only  One year from the date of this authorization OR		HEADACH	cs.
One year from the date of this authorization OR	AUTHORIZATION VALID FOR: (If nothing is checked	d below, this authorization is valid for this red	quest only.)
This request and for medical records of any future treatment of the type described above until:		(input data). This puthorization	applies to the
This request and for medical records of any future treatment of the type described above until:	records of the treatment received on or prior to the date	of this authorization.	applies to the
<ul> <li>I understand that:         <ul> <li>My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).</li> <li>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 prior authorization.</li> <li>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 treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.</li> <li>There may be a charge for the requested records.</li> <li>The medical records requested above may be faxed in cases of medical necessity.</li> </ul> </li> <li>Signature of Patient or Representative</li> </ul>	☐ This request and for medical records of any future treat	tment of the type described above until:	(insert date)
<ul> <li>Circumstances (e.g. non-emergent mental health or chemical dependency treatment).</li> <li>I may cancel this authorization at any time by submitting a <u>written</u> request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.</li> <li>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, <u>except</u> that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.</li> <li>There may be a charge for the requested records.</li> <li>The medical records requested above may be faxed in cases of medical necessity.</li> </ul>	Tunderstand that:		
<ul> <li>I may cancel this authorization at any time by submitting a <u>written</u> request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.</li> <li>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 treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.</li> <li>There may be a charge for the requested records.</li> <li>The medical records requested above may be faxed in cases of medical necessity.</li> </ul>	<ul> <li>My right to healthcare treatment is not conditional formation of the conditional formation in the condition in the conditional formation in the conditional formation in the cond</li></ul>	oned on this authorization, except in very lim	iited
<ul> <li>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 treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.</li> <li>There may be a charge for the requested records.</li> <li>The medical records requested above may be faxed in cases of medical necessity.</li> </ul>	<ul> <li>I may cancel this authorization at any time by:</li> </ul>	illin or chemical dependency treatment). Submitting a <i>written</i> request to the address i	nrovided at
<ul> <li>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 treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.</li> <li>There may be a charge for the requested records.</li> <li>The medical records requested above may be faxed in cases of medical necessity.</li> </ul>	the top of this form, except where a disclosure	has already been made in reliance on my i	orior
covered by privacy regulations, the information stated above could be redisclosed, except that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR 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.  Date	authorization.		
chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR 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	covered by privacy regulations, the information	n stated above could be redisclosed, except	ithat
There may be a charge for the requested records.     The medical records requested above may be faxed in cases of medical necessity.  Bignature of Patient or Representative	chemical dependency treatment records prote	cted by Federal Confidentiality Rules 42CF	R Part 2 may
The medical records requested above may be faxed in cases of medical necessity.  Signature of Patient or Representative	not be disclosed without my written authorizati	ION Unless otherwise provided for in the real	ılations.
Signature of Patient or Representative	The medical records requested above may be	faxed in cases of medical necessity.	
DateDate	Signature of Patient or Representative	Date:	
	Similar of Languit of Lebicocilique	Date _	

This authorization must be retained for a minimum of six years bound the volidation limits