UNIVERSITY of ROCHESTER MEDICAL CENTER

& 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

RR DONNELLEY

PLEASE PRINT

Patient name: _____ Date of Birth: _____

Address: _____ 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 discuss your information with) the provider/person/facility below

SCHOOL

_____ Name of Provider/ Person/Facility

_____ Address

_____ City, State, Zip Code

_____ Phone #/Fax # (include area code)

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)

- ☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
- ☐ Specific information or reports (describe): _____
- ☐ 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 Surgery visit ☐ Emergency Department Record

☐ Radiology report(s) ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)

☒ Other (describe): DISCUSSION OF ONGOING MANAGEMENT OF HEADACHE IN THE SCHOOL SETTING.

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)

I understand 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.
- 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 _____ Date _____

Relationship to Patient *(if Representative)* _____

Revised 9/13 *Distribution* Original to medical record. Copy to patient as required.

This authorization must be retained for a minimum of six years beyond the validation limits.

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THERAPIST / PSYCHIATRIST

PLEASE PRINT

Patient name: _____ Date of Birth: _____

Address: _____ Patient's phone#: ( ) _____

City/State/Zip: _____

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City, State, Zip Code	Phone #/Fax # (include area code)

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(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 COLLABORATE ON ONGOING MANAGEMENT OF HEADACHES.

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.
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