UNIVERSITY OF ROCHESTER MEDICAL CENTER

STRONG HEALTH

STRONG MEMORIAL HOSPITAL
Surgical Pathology
601 Elmwood Ave. Box 626
Rochester, NY 14642
Phone: 585-275-3191
Fax: 585-273-3637

SMH 48S-P MR

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

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

Date of Request: _____ **Date Needed:** _____

☐ I authorize Strong Health/URMC **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____/_____
Phone #/Fax # (include area code)

OR

☐ I authorize Strong Health/URMC **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____/_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other

TYPE OF RECORDS REQUESTED: (Check one)

☐ Inpatient: date(s) _____ ☐ Outpatient: date(s) _____

☐ Specific information (Select one or more, as applicable)
- ☐ Operative report ☐ History & physical ☐ Discharge Summary ☐ Laboratory test results
- ☐ X-ray reports ☐ Physical Therapy ☐ Other: _____ (Please describe)

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Entire copy of the inpatient/outpatient record checked above.

☐ All medical records related to a specific illness or injury.

_____
Specify illness/injury Date(s) of treatment

AUTHORIZATION VALID FOR: (Check one)

☐ 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.
- 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.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____