



& Affiliates



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Strong Memorial Hospital

Strong Fertility Center
500 Red Creek Drive
Suite 220
Rochester, NY 14623
P-(585) 487-3378
F-(585) 334-8998

SH 48SFC Authorization for Release/Disclosure of Medical and/or Behavioral Health Information

PLEASE PRINT:

Patient name: _____ Date of Birth: _____
Address: _____ Patient's phone#: () _____
City/State/Zip: _____

This Authorization allows URM & 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

_____	_____
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): _____

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 2/14

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.

RR DONNELLEY