



Health Information Management
845-858-7092 *telephone*
845-858-7408 *fax*

160 East Main Street
Port Jervis, New York 12771
www.BonSecoursCommunityHosp.org

Authorization For Disclosure of Patient Health Information

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

1. I authorize Bon Secours Community Hospital to disclose the following information from my health record as maintained by the Hospital:

- entire record
- emergency room record from _____(date)
- most recent discharge summary
- most recent history and physical examination report
- most recent operative report
- lab results from _____(date) to _____(date)
- radiology results from _____(date) to _____(date)
- consultation reports from (please supply doctors' names):
- progress notes
- medication lists
- other (please describe:

2. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name:

Address:

Name:

Address:

3. This information for which I am authorizing disclosure will be used for the following purpose

- my personal records
- sharing with other health care providers as needed
- other (please describe):

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, 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. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. Unless I specify differently, this authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

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

By signing this authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my health information maintained by Bon Secours Community Hospital in accordance with the terms of this Authorization.

_____ Signature of patient or legal representative If signed by legal representative, relationship to patient _____	_____ Date
--	---------------

_____ Signature of witness	_____ Date
-------------------------------	---------------

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

This authorization does not apply to disclosure of information relating to HIV/AIDS virus, Drug/Alcohol Abuse/Treatment or Mental Health Services. A special consent is required by New York State Law for disclosure of this protected health information.

<p>For Hospital Use:</p> <p>Picture Identification is shown Yes _____ No _____ If no, other form of I.D. shown is: _____(specify)</p>
--

A COPY OF THIS SIGNED AUTHORIZATION WILL BE GIVEN TO THE INDIVIDUAL.