CMA Authorization for Release of Health Information

Follow the instructions below when filling out the Authorization for Release of Health Information:

- Print name, birth date, address & phone number of patient whose medical records are being requested
- Fill out **#5** with the name, address, phone & fax number of **provider** or person that will be ***releasing the records***
- Fill out **#6** with the name, address, phone & fax number of **provider** or person that the ***information is being sent to***
- Fill in **#7** with the ***Purpose for Release of Information*** (ex. Moving, Treatment, Litigation)
- In **#8** indicate an expiration date or expiration event (CMA Authorization is auto-filled with "One year from signature date")

  Check what items should be released:
  - ✓ Medication List
  - ✓ Vitals
  - ✓ Immunizations
  - ✓ Progress Notes
  - ✓ Consults
  - ✓ Lab Results
  - ✓ Radiology/Test Results
  - ✓ Insurance/Billing Information
  - ✓ Other__________________
  - ✓ All Records – 3 years
  - ✓ All Records – 1 year

  *****When releasing sensitive information (Alcohol/Drug Treatment, Mental Health Programs, HIV/AIDS-related information) the patient will need to check which type & initial*****

- Fill in **#9** if it's not the patient signing the form; **#10** should state the description of the person signing on behalf of the patient (ex. Parent, Legal Representative); be sure to include any required documentation (Healthcare Proxy, Executor of Estate, POA, etc.) with signed authorization
- Patient or legal representative will sign & date the bottom of the authorization
- After completing and signing, please send this form to Medical Records, 1301 Trumansburg Road, Suite B, Ithaca, NY 14850. You may fax it to 607-272-1697 or email it to Medical_Records@cayugamedicalassociates.org.

For questions regarding this process, please contact our Medical Records Department at (607) 277-2365, Option 6.

Authorization for Release of Health Information

Patient Name	Date of Birth	Patient Identification Number

Patient Address	Patient Phone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Phone #: Fax #:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Phone #: Fax #:

7. Purpose for Release of Information:

8. Unless previously revoked by me the specific information below may be disclosed until one year from signature date.

Check Items to be released:

[ ]Medication List
[ ]Vitals
[ ]Immunizations
[ ]Progress Notes/History & Physicals
[ ]Consults
[ ]Lab Results
[ ]Radiology/Test Results
[ ]Insurance/Billing Information
[ ]Other____
[ ]All Records – Last 3 years
[ ]All Records – Last 1 year

Check which will be included and initial:

	Initials
[ ]Records from Alcohol/Drug Treatment Programs	__________
[ ]Records from Mental Health Programs	__________
[ ]HIV/AIDS-related Information	__________

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

____ ______________________

Signature of Patient or Representative Authorized by LAW Date