UNIVERSITY *of* ROCHESTER
MEDICAL CENTER

& Affiliates

48

Strong Memorial Hospital
Department or Practice ____________
601 Elmwood Avenue, Box #: ________
Rochester, NY 14642
Phone: (585) ____________ Fax: (585) ____________

SH 48 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 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

Name of Provider/ Person/Facility ____________ Address ____________

City, State, Zip Code ____________ Phone (fax if sending records) ____________

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:

- [illegible] 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 (42 CFR Part 2) [illegible]
- 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 ____________