MR # DOB

NAME

DATE

BASSETT HEALTHCARE NETWORK
☐ **A.O. FOX HOSPITAL**
Oneonta, NY 13820
☐ **BASSETT MEDICAL CENTER**
Cooperstown, NY 13326
☐ **COBLESKILL REGIONAL HOSPITAL**
Cobleskill, NY 12043
☐ **LITTLE FALLS HOSPITAL**
Little Falls, NY 13365
☐ **O'CONNOR HOSPITAL**
Delhi, NY 13753

Medical Record Number _____
For Office Use Only

☐ **Clinic** _____

AUTHORIZATION FOR MEDICAL RECORD RELEASE

H-6653 5/03;3/04;2/05;7/06;3/12;4/16;9/17;2/18 (d:\forms\hosp\.ofm)

SECTION A

Patient Name | Date of Birth | Phone Number

Address | City, State | Zip

Please do not disclose information regarding: ☐ HIV ☐ Genetic Testing ☐ Alcohol & Drugs ☐ Psychological or Psychiatric ☐ Pregnancy

The releasing provider listed above is hereby authorized to release information from the medical records of the above named patient. This authorization permits release of information to include information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV-related test, HIV infection, HIV-related illness, AIDS or any information which could indicate potential exposure to HIV, and any information related to or regarding genetic testing.

I understand that Bassett Healthcare Network will not condition treatment on my providing authorization for disclosure. I further understand that I do not have to allow the release of this information in part or entirety. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Bassett Healthcare Network, Release of Information, or the site releasing the records. I understand that a revocation will not apply to information that has already been released.

I understand that the information to be released from the medical record is confidential and will not be released except to the person/institution named below. I acknowledge that any disclosure to a third party can lead to unauthorized re-disclosure by that person or others, which may not be subject to federal or state confidentiality laws.

Name and address of Provider/ Institution Releasing Information: _____

Name and address of Person/ Institution Information Sent To: _____

Extent of Information to be Released (Include dates, providers etc.) _____

Upcoming Appointment Date _____

RELEASE OF INFORMATION Request

Section B is required if the patient has received substance abuse services

SECTION B

The following information may be shared:

- ☐ Patient's involvement in MAT (medication assisted treatment) services
- ☐ Medical history and physical information
- ☐ Psychological test results/treatment history, psychiatric evaluations
- ☐ Lab data (urine, BAC results)
- ☐ MAT Program Status
- ☐ Patient's Care Plan
- ☐ Discharge plan/summary
- ☐ Treatment recommendations
- ☐ Criminal justice information (probation, parole, court orders)
- ☐ Social service record / plans / compliance / forms
- ☐ Other (specify) _____

The above information may be disclosed for the following purpose(s)

- ☐ Facilitate a treatment referral for chemical dependency or physical or mental health services
- ☐ To assist in obtaining insurance, employment or government benefits
- ☐ To complete a comprehensive assessment of the patient
- ☐ To assist patient in compliance with parole, probation, Drug court or other Court requirements
- ☐ Other (specify) _____

NOTICE TO THE PATIENT: I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. PTS. 160 & 164; and that re-disclosure of this information to a party other than the one designated above is forbidden with without additional written authorization on my part.

SECTION C

Release valid for one year from signature date, unless otherwise specified here: _____

_____/_____ _____
Signature of patient, parent or legal guardian (relationship) Date

_____/_____ _____
Signature of witness Date Address of witness

I am authorizing Bassett Healthcare Network to discuss my health information with _____. This authorization is valid until revoked.

NOTICE TO THE RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.