

**RIVER HOSPITAL** *Serving the Thousand Island Region*

4 Fuller Street

Alexandria Bay, NY 13607

Phone 315-482-2511 fax 315- 482-7506

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Authorization Expires: 90 days from today

To: (Name & Address of Doctor or Institution) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the release/obtaining of my general protected health information to/from River Hospital, 4 Fuller Street, Alexandria Bay, NY 13607.

Information to be released/obtained: Check all that apply and enter date of service:

_____ Complete health record	_____ ER Record	_____ Consultation Reports
_____ History & Physical	_____ Laboratory Tests	_____ EKGs
_____ Operative Report	_____ X-Ray Reports	_____ Other _____

\*Information not to be released: \_\_\_\_\_

The purpose of this request:

_____ Continuity of Patient Care	_____ Compensation/Disability	_____ Personal Records
_____ Insurance/Payment of Bills	_____ Legal	_____ School

Other (please specify) \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying the River Hospital in writing, but if I do it will not have any effect on any actions taken before they received the revocation. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that I may see a copy of the information described on this form and that I will get a copy of this form after I sign it if I ask for it. I understand that in compliance with New York statute, copies of records for personal use will be charged at \$ .75 a page. Copies for continuity of care will be sent directly to the physician or health care facility at no charge.

This protected health information is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged, confidential and exempt from re-disclosure under applicable law. It is understood that River Hospital is released from all legal responsibility which may arise as a consequence of honoring this request.

*Your signature on this form must be witnessed by another person of legal age. Please do not sign this form unless a witness is present.*

\_\_\_\_\_  
Signature of Patient or Individual authorized to sign on  
Patient's behalf.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed Name