AUTHORIZATION FOR RELEASE OF PROTECTD HEALTH INFORMATION

BON SECOURS CHARITY HEALTH SYSTEM
Bon Secours Health System

I hereby authorize the use of disclosure of my protected health information (PHI) from my medical record as described below. This may include medical, psychological, mental health, HIV, drug and/or alcohol abuse information. I understand that this authorization is voluntary.

Patient Name		**Today's Date**
Date of Birth	**Phone Number**	**Medical Record Number**
Mailing Address	**City/Town**	**State** **Zip Code**

Description of information that may be disclosed:

- ☐ Emergency Room Record Date (s) of service:_____
- ☐ Inpatient Record
- ☐ Outpatient Record
- ☐ Other_____

If the requested portion of the record contains information related to drug/alcohol, mental health or HIV related information, you must specifically consent to the release of such information by initiating here_____(must initial)

Organization Providing the Information

- ☐ Bon Secours Community Hospital
  160 East Main Street
  Port Jervis, NY 12771-2253
- ☐ Good Samaritan Regional Medical Center
  255 Lafayette Avenue
  Suffern, NY 10901
- ☐ St. Anthony Community Hospital
  15 Maple Avenue
  Warwick, NY 10990

Persons/Organization receiving the information:

_____
Name
_____
Street Address
____ _____
City/Town State Zip
_____
Phone/Fax

1. The information will be used/disclosed for the following purposes:_____
2. I understand that I may inspect/receive a copy of the PHI described by this authorization upon payment of a reasonable fee.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations
4. (If applicable) I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.
5. I understand that I my refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may see or copy the information used/disclosed under this authorization and that I can get a copy of this form after I sign it.
6. I understand that I may revoke this authorization in writing at any time by notifying the providing organization in writing, but if I don it won't affect any actions they took before they received the revocation
7. I understand this authorization expires on ____/____/____ or 1 year after being signed.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

_____ _____
Signature of Licensed Independent Professional Authorizing Release Printed Name of LIP

Nov 2012