The Brooklyn Hospital Center
Keeping Brooklyn healthy.

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SECTION A

Patient Name: _____ **Med. Rec. #:** _____

Street/Apt.: _____ **Date of Birth:** _____

City, State, Zip: _____ **Telephone #:** _____

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by the federal privacy regulations.

SECTION B

I am requesting the following information:

☐ ALL Medical Information covering records from: (Date) _____ to (Date) _____

☐ Medical Information confined to the following specific information _____

☐ Abstract of Date: _____ to (Date) _____

SECTION C

Please release information to:

Name: _____

Address: _____

For the purpose of: _____

I understand that as a **patient**, **I will be charged $.12 a page for copying** and additional charges for mailing this information.

SECTION D To be **READ AND INITIALED** by patient/patient's representative. **THIS SECTION MUST BE COMPLETED. This authorization/consent will expire when acted upon or 90 days from the signed date, whichever occurs first.**

____ I understand that I will get a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the hospital in writing, but if I do, the revocation will not have any effect on actions the hospital has already taken in reliance on this authorization.

____ I understand that if my records contain information concerning drug, alcohol, or mental health treatment such information will be released pursuant to this release form.

____ I understand that if my records contain confidential HIV related information (indicating that I have had an HIV related test, or have HIV infection, HIV related illness or AIDS, or that could indicate that I have been potentially exposed to HIV), such information will be released pursuant to this consent form. The recipient of this information is prohibited from re- disclosing HIV related information without my authorization unless permitted to do so under federal and state law. I also have the right to request a list of people who may receive or use my HIV related information without authorization.

_____ _____ **Notary/ Hospital Personel**

Signature of Patient or Patient's Representative **Date**

_____

Printed Name of Patient or Patient's Representative ☐ **Pick Up** ☐ **Mail**

_____

Relationship to Patient ☐ **Email**