ROME MEMORIAL HOSPITAL

1500 North James Street, Rome, New York 13440
(315) 338-7133

Place Patient Sticker Here

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ _____ _____
Last First Middle Birth Date Age

ADDRESS: _____ _____
Street City State Zip Code Phone

The above named patient hereby authorizes and requests _____ to provide:

NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

_____

FOR THE PURPOSE: _____

Information to be released: _____

_____

which may be inclusive of the history, diagnostic and therapeutic information including **PSYCHIATRIC CARE AND ANY TREATMENT FOR ALCOHOL AND DRUG ABUSE.**

EXCEPTION to information released: _____

This authorization shall be in effect for one year or until _____(Date of Expiration) at which time this authorization to use or disclose this protected health information expires.
I understand that, as set forth in the hospital's Notice of Privacy practices, I have the right to revoke this authorization in writing, at any time by sending written notification to Rome Memorial Hospital, 1500 North James Street, Rome, New York 13440, ATTN: Privacy Officer.

- I understand that a revocation is not effective to the extent that the hospital has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the hospital will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

_____ _____
Patient Signature Date/Time

OR _____ _____
Personal Representative Signature Relationship To Patient

_____
Witness Signature

FIRST ORDER

_____
Distributee Signature Date/Time

☐ Spouse (still married)
☐ Children, if spouse is deceased
☐ Grandchildren, if the children are deceased

SECOND ORDER

_____
Distributee Signature Date/Time

☐ Parents

THIRD ORDER

_____
Distributee Signature Date/Time

☐ Siblings

This authorization must be signed by the patient. If the patient is under 18 or is physically unable, the authorization is to be signed by the nearest relative. In cases of mental incompetence, the legal guardian must sign.