Cayuga HEALTH

ITHACA COLLEGE
Student Health Services

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form. **FEES: Health records will be sent to another healthcare provider free of charge as a professional courtesy. All other requests are subject to fees of $.75 per page. Health records are released upon payment of all fees.**

Name - Last, First, MI (Maiden or former name) | Date of Birth

Street Address | City | State | Zip Code

Phone

Specific description of Information (including dates): | **Date Needed:**

- ☐ Abstract (all dictated notes, labs, Radiology Reports, EKGs)
- ☐ Labs/Pathology
- ☐ Physical Therapy
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Cardiac/EKG
- ☐ Radiology Report ☐ Disc
- ☐ Emergency Record/Urgent Care
- ☐ Operative Report
- ☐ Other:
- ☐ Office Notes

Drug, Alcohol, HIV and Mental Health
I authorize by initialing any of the below, that they shall be included in this request:
Drug _____ Alcohol _____ Mental Health _____ HIV _____

Format for Record Delivery: (Select ONE) ☐ Paper ☐ DVD (required PDF viewer) ☐ Other (specify):
Please note: If a format is not selected, records will be provided in paper format.

☐ **Release Information FROM: (Select One)**
- ☐ Cayuga Medical Center
- ☐ Cayuga Medical Associates
- ☐ Schuyler Hospital

Name - (e.g. Health Facility, Provider)

Address

City | State | Zip

Phone | Fax

☐ **Release Information TO: **Need Full Mailing Address****
- ☐ Cayuga Medical Center (Fax 607-274-4131)
- ☐ Cayuga Medical Associates (Fax 607-277-0104)
- ☐ Schuyler Hospital (Fax 607-535-6210)

Name - (e.g. Insurance Company, Lawyer, Provider, Patient)

Address

City | State | Zip

Phone | Fax

What is the purpose or need for disclosure?

I understand I may revoke this authorization at any time by presenting written revocation to the Health Information Management Department. Revocation will not apply to information already released in response to this authorization. I understand that any release of information carries with it the potential for redisclosure by the recipient and may not be protected by the federal privacy rules. Cayuga Health will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date or event) _____. If you leave blank, the authorization will expire after 6 months. The patient may request a copy of this authorization.

_____ **Signature**

Date

Relationship, if not patient:

953 Danby Rd, Ithaca, NY 14850 Fx: (607) 821-1650