MONTEFIORE NYACK HOSPITAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Montefiore Nyack Hospital to release the following information from the medical records of:

NAME OF PATIENT _____ DATE OF BIRTH _____ TELEPHONE NUMBER _____

RELEASE THE REQUESTED RECORDS TO:

PATIENT

Name of the Patient _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

Email _____, I understand that in order to receive this information in electronic format, I must provide my email address on this form and that I must also send an email from that address to ROI@montefiorenyack.org.

ATTORNEY

Name of the Attorney _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

OTHER INDIVIDUAL/COMPANY

Name of the Other/Individual _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

MEDICAL RECORDS TO BE RELEASED (PLEASE SPECIFY THE DATES OF SERVICE)

An abstract of your medical record will be released which includes physician documentation, labs, radiology reports, and test results **unless you request the entire medical record**.

Please select all that apply:

☐ ER RECORD ☐ INPATIENT RECORD ☐ OUTPATIENT RECORD ☐ IMAGES ☐ BILLING

If you would like a specific document, please list it here: _____

☐ Alcohol/Drug Treatment ☐ Mental Health Information (excluding Psychotherapy Notes) ☐ HIV - Related Information ☐ Deceased

PLEASE READ AND COMPLETE THE FOLLOWING:

I understand that I may revoke this authorization at any time by notifying Montefiore Nyack Hospital in writing, but if I do, it won't have any affect on any actions they took before the received revocations. You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days (six months) from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. I further understand that the specific type of information to be disclosed may, if applicable, include: Diagnosis, Prognosis, and treatment for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection for any admissions.

I understand that this authorization will expire on the following date: ___ ___ _____ Initials: _____

_____ _____

DATE SIGNATURE OF PATIENT

_____ _____

PARENT OR GUARDIAN [ ] Health Care Proxy [ ] Power of Attorney CONSENT OF MINOR (WHEN APPLICABLE)

Montefiore Nyack Hospital
Health Information Services
160 North Midland Avenue
Nyack, NY 10960
845-348-2527 Office
845-348-8433 Fax
ROI@montefiorenyack.org

Montefiore | Nyack

Montefiore | Nyack

Montefiore Nyack HIPAA Authorization Instructions

Given the heightened concerns related to the spread of COVID-19, we ask that you please fax/and or email your completed Authorization Forms.

Fax Number: 845-348-8433
Email: ROI@montefiorenyack.org

Instructions for the form are as followed:

- If the records are strictly for the patient, please fill out the section titled Patient.
- If you would like a secure e-mail, please provide your e-mail address on the form. Following your submission please send an e-mail to: ROI@montefiorenyack.org with; patients Name, requestors name and date of birth. This is part of our two step verification to ensure the protection of your health information.
- If someone else is picking up the records on behalf of the patient, please have their information filled out in the section titled Other Individual/Company.
- If the records are for your doctor, please fill out the doctor's information where it states Other Individual/Company.
- If records are going to more than one person, please complete one form per recipient (i.e. if records are going to the patient AND a doctor, please complete one form for the patient and one form for the doctor; a total of two forms must be completed).
- Please include the date of service and/or tests being requested.
- Please provide a copy of your photo identification.

Personal Representative

If the patient is unable to sign the authorization, copies of one of the following documents would have to be provided:

- Healthcare Proxy **OR**
- Medical Power of Attorney **OR**
- Guardianship Letter

Deceased Patients

If the patient is deceased a copy of the death certificate must be provided along with **one** of the following documents;

- Letter of Administration **OR**
- Letters Testamentary **OR**
- Distributee Affidavit

Montefiore | Nyack

Minors

Parents of minors (under 18 years of age), next of kin or legally appointed guardians, may obtain a copy of a minor's record.

Exception:

If a minor from the ages of 12 -17 was treated for sexually transmitted disease, birth control treatment, drug/alcohol abuse treatment, HIV or mental illness, the records can only be released upon the **minor's authorization**.

New York State Public Health Law allows Montefiore Nyack Hospital to charge a reasonable fee to recover the costs of copying, mailing and supplies used to fulfill your request. Patients will receive a pre-bill or a payment notice with their records. However, there is no fee if the record is being released to a doctor or healthcare provider for continuity of care.

Once the authorization is completed you can mail, email or fax the release form to the contact information below.

Authorizations are processed within 7 to 10 business days of receipt.

Fees for Copies of Medical Records

- Paper - 0.75 cents
- CD – 6.50
- Email – No Charge

Any questions or concerns please feel free to reach out.

ROI
Department of Medical Records
Montefiore Nyack
A member of the Montefiore Health System
160 North Midland Ave, Nyack, NY 10960
Office: (845) 348-2527
Fax: (845) 348-8433
Roi@MontefioreNyack.org