

SUNY Upstate Medical University University Hospital

INSTRUCTION SHEET FOR COMPLETING THE 'HIPAA COMPLIANT AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION AND CONFIDENTIAL HEALTH INFORMATION'

Directions: Please complete all sections of the form. Blank lines must be crossed out.

- My HIV-related Information
- Both (non-HIV and HIV -related information)
- My Non-HIV medical information.

Check the appropriate box to indicate the type of information to be released. Please note that University Hospital uses this form as its standard form for all disclosures.

- Name and address of facility disclosing HIV-related and/or medical information:

The name of the hospital, clinic, doctor's office, nursing home, etc. to which the patient is giving permission for release/copy their medical records. This is a universal form and can be used for disclosure by University Hospital or to request records from another healthcare provider or facility such as Crouse or St. Joseph's Hospital.

- Name of person/patient whose information will be released:

The name of the patient whose medical records are being released/copied.

- Name and address of person signing this form (if other than above):

Complete only if the authorization is not completed by the patient but by their legal guardian or personal representative.

- Relationship to person whose information will be released:

Complete only if the authorization is completed by a patient's legal guardian or personal representative.

- Describe information to be released:

- Date:

This is the date the form is signed.

Page 2 – Complete information for each facility/person to be given general medical and/or HIV related information. Attach additional sheets as necessary. Blank lines must be crossed out prior to signing.

- Name and address of facility/person to be given general medical and/or HIV-related information:
The name of the physician/health care provider/facility receiving copies of the patient's medical information.
- Reason for release, if other than stated on page 1:
The reason the patient is allowing his/her medical records to be copied and released. For example; coordination of care, legal proceedings, insurance purposes, patient request etc.
- If information to be disclosed to this facility/person is limited, please specify:
Any restrictions to the information to be released should be specified here.
- Signature:
The signature of the patient or the patient's representative. This signature verifies that all questions have been answered and the patient or patient's representative is aware of their rights as listed.
- Date:
This is the date the form is signed.
- If legal representative, indicate relationship to subject:
List relationship, ie. attorney, parent, etc.
- Print Name:
Used in clarifying signature.
- Client/Patient Number:
Enter the patient's account number or medical record number.

Prior to signing the form on page 2, a patient or the patient's representative can add authorized individuals or facilities by completing the page 3 addendum and signing at the bottom. Any unused spaces on the addendum page must be crossed out prior to the patient signing.

Individuals and/or facilities cannot be added to the authorization once the authorization has been signed. A new authorization must be completed.