

**Health Information Systems**

845-368-5000 x.6248 or x.6249

845-368-5346 (fax)

**GOOD SAMARITAN HOSPITAL**

Bon Secours Charity Health System

255 Lafayette Avenue  
Suffern, NY 10901-4869

*www.GoodSamHosp.org*



**Authorization For Disclosure of Patient Health Information**

Patient Name: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. I authorize Good Samaritan Hospital to disclose the following information from my health record as maintained by the Hospital:

- \_ entire record
- \_ emergency room record from \_\_\_\_\_(date)
- \_ most recent discharge summary
- \_ most recent history and physical examination report
- \_ most recent operative report
- \_ lab results from \_\_\_\_\_(date) to \_\_\_\_\_(date)
- \_ radiology results from \_\_\_\_\_(date) to \_\_\_\_\_(date)
- \_ consultation reports from (please supply doctors' names):
- \_ progress notes
- \_ medication lists
- \_ other (please describe): \_\_\_\_\_

2. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

3. This information for which I am authorizing disclosure will be used for the following purpose:

- \_ my personal records
- \_ sharing with other health care providers as needed
- \_ other (please describe): \_\_\_\_\_

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. Unless I specify differently, this authorization will expire (insert date or event):\_\_\_\_\_

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

6. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the disclosure of my health information maintained by Good Samaritan Hospital in accordance with the terms of this authorization.

**- A Copying and Processing Fee May Be Charged**

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

*I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.*

*This authorization does not apply to disclosure of information relating to HIV/AIDS virus, Drug/Alcohol Abuse/Treatment or Mental Health Services. A special consent is required by New York State Law for disclosure of this protected health information.*

**For Hospital Use:**

Picture Identification is shown Yes \_\_\_\_\_ No \_\_\_\_\_

If no, other form of I.D. shown is: \_\_\_\_\_(specify)

**A COPY OF THIS SIGNED AUTHORIZATION WILL BE GIVEN TO THE INDIVIDUAL**