MVHS® Faxton St.Luke's Healthcare Utica, NY

* R O I 4 *

Patient Sticker Or	MR#:
	Acct#:

Patient Access Request

Patient Name: _____ Date Of Birth: _____

Address: _____ Phone Number: _____
Street City Zip

1) I authorize Faxton St. Luke's Healthcare _____
(Medical Center / Medical Group Site)

Internal Use Only: ☐ Pick Up ☐ Mail
☐ FOC (proof obtained) ☐ Request to Physician
☐ Extended Release ☐ See Distributee Form

☐ **TO RELEASE this patient's information to**	☐ **TO OBTAIN this patient's information from** ☐ Patient Being Seen Right Now ➡ Fax records to # _____ ➡ To the Attention of: _____
Name:	
Address:	
City/State/Zip Code	
(Area Code) Phone:	(Area Code) Fax Number:

2) Description of information that may be disclosed (check off the appropriate items):

Date(s) of Service: _____ _____ _____ _____

☐ Abstract of Hospital Record (ED/dictations/tests) ☐ Entire Medical Record ☐ Labs / Radiology *(Films must be requested from the Radiology Dept. directly)*

☐ History & Physical / Op Report / Discharge Summary ☐ Emergency Dept. Record ☐ Immunization Records

☐ Confined to records regarding the following medical condition/injury: _____

☐ Other (please describe) _____

* **Specific authorization is required to release the following documentation. If authorizing release, please check and initial**

☐ _____ Substance Abuse Records (initial)

☐ _____ Psychiatric Records (initial)

*HIV (requires separate NYS release form, please ask for assistance)

3) Media Type: ☐ CD ☐ Paper

4) Optional Extended Release: ☐ _____ (initial) I authorize the release of future healthcare visits generated/created within ___ months after the date of signature on this release.

5) I understand that: • By signing this form I am authorizing the release of my medical records • I can request a copy of this form • I may be charged for labor, shipping, and supply costs • I may revoke this authorization in writing at any time by completing the bottom of this form or by contacting the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. This authorization expires on: _____ (insert applicable date or event), or within 1 year of the date of the authorization, whichever is greater.

6) Date: _____ **Time:** _____ **Signature of Patient/Legal Representative:** _____
(DO NOT SIGN A BLANK FORM)

If Legal Representative, relationship to patient: _____

Date: _____ Time: _____ Signature of Language Interpreter (if Applicable): _____

REVOCATION *I am revoking this authorization and no longer authorize records to be released as of the date below.
Date: _____ **Time:** _____ **Signature of Patient/Legal Representative:** _____
Date: _____ **Time:** _____ **Witness Signature:** _____