Cayuga MEDICAL CENTER
A Member of Cayuga Health System

Office Use Only:
MR # _____
Acct. # _____

ID Checked: ☐ Yes ☐ No
If No checked, why: _____

Authorization for Release of Information

When requesting health information records, please be very specific to ensure you receive all the information you require. Also, please be advised that Health Information Management will process fully completed Authorization forms as required by federal law (HIPAA). Incomplete Authorizations will be returned to sender with explanation as to what is missing.

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.

I hereby authorize Cayuga Medical Center to release copies of my medical records as directed below to:
(please enter complete mailing address)

Name: _____
Address: _____
Phone #: _____ Fax #: _____

DESCRIPTION OF INFORMATION:

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Dates of Service: _____ Date Needed By: _____
(Normal Processing Time if No Date)

INFORMATION TO BE RELEASED:

☐ History & Physical
☐ Discharge Summary
☐ Consultation
☐ EKG
☐ Occupational/PT
☐ ER/Convenient Care
☐ Laboratory Results/Pathology
☐ X-ray Reports ☐ Disc
☐ Operative Report
☐ Record Abstract
☐ Accounting of Disclosure
☐ Billing Communication
☐ Other: _____

Includes: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV/STI-Related Information

REASON FOR RELEASE:

☐ At request of individual ☐ Other: _____

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 Medical Center will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date or event) _____.
If I fail to specify an expiration date or event, this authorization will expire after 6 months. The patient may request a copy of this authorization.

_____ _____
(Signature of patient or legal representative) (Date) (Must be entered or request will be returned)

_____ _____
(Relationship, if other than patient) (Legal Representative Address)

*****Please scan completed form and email to: medicalrecords@cayugamed.org**
or send completed form to the Health Information Department at the address below***

101 Dates Drive ● Ithaca, New York 14850 ● (607) 274-4011

Cayuga
MEDICAL CENTER
A Member of Cayuga Health System

Authorization for Release of Information

Please follow the instructions below when filling out the Authorization for Release of Information form:

- Print name and address of the recipient of where records are being released to
    - Name and complete address are required.
- Description of Information
    - Print patient name, date of birth, address, date(s) of service (exact, time span, or event), and when copies are needed.
- Information to be Released
    - Please mark the checkbox for the information being requested, if not listed please mark the other box and write in information needed.

*****When releasing sensitive information (Alcohol/Drug Treatment, Mental Health Programs, HIV/AIDS- related information) the patient will need to INITIAL each line.*****

- Reason for Release
    - Please check why the records are being requested.
- Expiration of Release
    - If no expiration date is written, release will expire 6 months from the date of the signature.
- Form must be signed and dated by the patient/legal representative to be valid.
    - Please provide the relationship of legal representative and any required documentation (Healthcare Proxy, Original Executor of Estate, POA, death certificate with raised seal, etc.) with signed authorization.

Authorization for Release of Information forms can be found at:

- In Office
    - We are located at 101 Dates Drive Ithaca, NY on the first floor.
    - Office hours Monday-Friday 7am-5pm.
- Online
    - cayugamed.org
    - Under Contact Us, click the blue link for Authorization for Release of Information.
    - Print form and complete.
- Mail/Email
    - We are happy to mail/email a request to you, at your request.

Authorization for Release of Information forms can be returned to us by:

- Mail/In Person- Cayuga Medical Center Health Information Dept. 101 Dates Drive Ithaca, NY
- Email- medicalrecords@cayugamed.org
- Fax- 607-274-4131

Please feel free to call Medical Records if you have any questions at 607-274-4314.