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)

____
____
____

DESCRIPTION OF INFORMATION:

Patient Name: ______________________________ Date of Birth: ______________________________
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
☐ Operative Report
☐ Record Abstract
☐ Accounting of Disclosure
☐ Billing Communication

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

☐ Other: ____

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) (Date)

____
(Address of Patient/Legal Representative/Family Relationship)

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

17130 (06/25/18)

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

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