Long Island
Community Hospital
101 Hospital Road
Patchogue, NY 11772

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Authorization to Disclose Health Information

Patient Name:_____ Date of Birth:_____

Treatment Dates:_____ Medical Record #_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

   Long Island Community Hospital
   101 Hospital Road, Patchogue, NY 11772

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

____discharge summary
____consultation reports from (doctors' names)_____
____discharge instructions
____EKGs (electrocardiograms)
____history and physical
____laboratory results from (date)_____to (date)_____
____medication records
____operative report
____pathology report
____x-ray and imaging reports from (date)_____to (date)_____
____entire record
____Wound Care Record
____Bellport Primary Care Record
____ other_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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5. This information may be disclosed to and used by the following individual or organization:_____

   Address:_____

   For the purpose of:_____

6. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Compliance Office at 631-687-2953.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

_____
Signature of Witness

For Internal Use Only

Fee for Records_____ Date Bill Mailed/Pt called_____

Patient Phone #_____ Alt. Phone #_____

Date/Time of Appointment_____ Appointment Verified_____

Date Doctor Called_____ Doctor's Reply_____

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