Long Island Community Hospital

RI0020

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone # : _____

_____ Medical Record #: _____

I hereby authorize Long Island Community Hospital to disclose the following information from my health record:

Dates of Treatment being requested: _____

❑ Abstract (subset of records) ❑ Entire Record ❑ Discharge Summary ❑ History and Physical
❑ Emergency Record ❑ Cardiology Reports
❑ Operative/Procedure Reports (If applicable, specify Provider's name) _____
❑ Consultation Reports (If applicable, specify Provider's name) _____
❑ Pathology Reports ❑ Laboratory Results ❑ Radiology Reports
❑ Bellport Primary Care Record ❑ Wound Care Record
❑ Hemodialysis Record ❑ Homecare/Hospice Record
❑ Other (please specify) _____

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

_____

Address: _____

Phone number: _____

Fax number: _____

For the purpose of: _____

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

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.
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 unauthorized re-disclosure 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.