



**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: \_\_\_\_\_

The records can be received by the following:  Printed Copy     CD

Electronic download / E-mail to: \_\_\_\_\_

\*Please note: email is not a secure method of transmission of your health information. Long Island Community Hospital is not responsible for the privacy of this information emailed at your request.

\_\_\_\_\_  
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.