AUTHORIZATION FOR PATIENT ACCESS AND/OR
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Read Entire Document before Signing)

Patient Name: _____ Maiden/Previous Name: _____

Date of Birth: _____ Phone #: _____ Medical Record #: _____

Account #: _____

Address: _____ _____
Street City / State / Zip

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:

Brooks-TLC Hospital System, Inc.
Dunkirk, NY 14048 - Irving, NY 14081

3) Description of information to be used or disclosed:

Description	Date(s)	Description	Date(s)
☐Discharge Summary		☐Clinic Notes	
☐History / Physical		☐Immunization Records	
☐Operative Reports		☐Lab Results	
☐Cardiac Cath Reports		☐X-ray Reports	
☐Emergency Department		☐Caregiver designation (Aftercare Instructions)	
☐Physical Therapy		☐Other	

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

Name: _____ Telephone: _____

Address: _____ _____
Street City / State / Zip

OR

I am interested in ☐inspection or ☐copies of my medical record

OR

I authorize _____
Identity of patient or name of qualified representative

to access my medical/hospital records for inspection and/or copies.

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5) I understand that:
   a) I may refuse to sign this authorization and that it is strictly voluntary.
   b) My refusal to sign this authorization will not affect my ability to obtain treatment; except when health services are solely for the purpose of reporting to a third party.
   c) I may revoke this authorization at any time in writing, but in do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
   d) Once the information listed above has been disclosed, it may be re disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.
   e) I may see and obtain a copy of the information described on this form for a reasonable copy fee.

6) This authorization will expire 90 days from the date of signature unless you request an earlier date or event.
   Expiration Date: _____ Event: _____

7) **Specially protected information** (please check all that apply)

   ☐ I understand that the information to be disclosed may include information relating to AIDS or HIV.

   ☐ I understand that the information to be disclosed may include information relating to psychiatric or other mental health treatment.

   ☐ I understand that the information to be disclosed may include information about treatment for drug, alcohol, or substance abuse.

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signed: _____ Date: _____ Time: _____
(Patient / Nearest Relative / Health Care Agent)

Relationship: _____

Witness: _____ Date: _____ Time: _____

Witness/Interpreter (if needed): _____ Date: _____ Time: _____

*****Photo ID is required for records to be picked up.*****

Staff Use Only

☐ **Released the complete information requested on page 1.**

☐ **Unable to release** _____ **due to** _____ .

Signature: _____ Date: _____