Patient Identifier

Name:
Med. Rec. #: *Date of Birth:*
Visit #: *Age:*
Service Date: *Insurance:*
Room: *Service Time:*

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Patient Name	**Date of Birth**	**Patient Identification Number/Social Security Number**
Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDSRELATED INFORMATION, except psychotherapy notes, only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I also understand that any disclosure/ release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

□ **Erie County Medical Center Corporation/Terrace View 462 Grider St., Buffalo NY 14215;** □ **Adult, Child & Family clinic 462 Grider St., Buffalo, NY 14215** □ **Depew Clinic 5089 Broadway, Depew NY 14043** □ **Downtown Clinic 1285 Main St. 2nd Floor, Buffalo NY14209** □ **Downtown Clinic 1285 Main St. 1st Floor, Buffalo, NY 14209** □ **Northern Erie Clinical Services, 2282 Elmwood Ave. Kenmore, NY 14217** □ **Center for Bariatric & Metabolic Surgery 30 North Union Rd. Suite 104 Williamsville, NY 14221**

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Specific information to be released:

□ Medical Record from (insert date)_____to (insert date)_____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

□ Other:_____ Include: *(Indicate by Initialing)*

_____ Alcohol/Drug Treatment
_____ *Mental Health Information
_____ HIV-Related Information

9. This consent shall expire six (6) months from its signing, unless a different time period, event or condition date is specified here:

10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____
Signature of patient or presentative authorized by law Date

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative if filled out at facility.

_____ _____
Signature of witness Date

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Erie County Medical Center / Terrace View Long-Term Care / Synergy Bariatrics

ECMC Downtown Clinic Services / ECMC Depew Clinic / Northern Erie Clinical Services

Correspondence Department
462 Grider Street
Buffalo, NY 14215
PH: 716-898-3257 FAX: 716-898-5358

Ciox is a contracted release of information vendor here at **ERIE COUNTY MEDICAL CENTER CORPORTATION** in Health Information Management Services.
Below are the standard fees for producing a copy of your medical records by Ciox.

Access Fees for PATIENTS ONLY:

- Electronic records delivered in electronic format $6.50
- Electronic medical record with paper records delivered in Electronic format are billed at $6.50 + $0.07 per page labor cost to create and deliver the portion of the record maintained in paper
- Electronic records delivered in paper $0.90 labor cost to create and deliver the portion of the record maintained electronically plus $0.05 per page for paper and toner
- Paper records delivered in electronic format $0.07 per page labor fee
- Paper records delivered in paper $0.12 per page Plus postage and taxes

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There is no charge for continuity of care if records are sent directly to your physician.

Please allow up to 30 days for processing.