

RELEASE OF HEALTH INFORMATION AUTHORIZATION

****Please print out in BLACK ink on plain white paper and use a BLACK ink pen to complete****

John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777



Patient Label



I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may not longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone #: _____ MR# _____

Persons/Organizations authorized to disclose my information:

Persons/Organizations who may receive my information:

Specific description of information to be disclosed (including dates):

Description of the purpose of the disclosure of my patient information:

1. I understand that this authorization will expire on ___/___/_____ or in 12 months from the date listed below.
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.
3. I understand that I may revoke this authorization at any time by notifying the providing organization disclosing my patient information in writing, but if I do, the revocation will not have any effect on actions the organization has already taken in reliance on this authorization.

This form MUST be completed before signing.

(Signature of patient 18 years older patient's representative)

Date

(Parent or Guardian)

Date

RECORDS REQUESTED TO GO DIRECTLY TO PATIENT OR FAMILY MEMBER REQUIRE NOTARIZED SIGNATURE IF RETURNED BY MAIL.

Authorized Signature: _____ Date _____

Notary Public: _____ Date _____