Cayuga MEDICAL CENTER
A Member of Cayuga Health System

Office Use Only: MR # M597460
Acct. # A88518428
ID Checked: ☐ Yes ☐ No
If No checked, why: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

When requesting health information records, please be very specific to ensure you receive all the information you require. Also, please be advised that Health Information Management will process fully completed Authorization forms as required by federal law (HIPAA). Incomplete Authorizations will be returned to sender with explanation as to what is missing.

FEES: Health records will be sent to another healthcare provider free of charge as a professional courtesy. All other requests are subject to fees of $.75 per page. Health records are released upon payment of all fees.

I hereby authorize Cayuga Medical Center to release copies of my medical records as directed below to:
(please enter complete mailing address)

Processed by: _____
Date Completed: _____
APR 06 2020
Fax _____ Mail _____ Picked up _____
Total Pages: _____

Name: Robert Breiman MD (PCP)
Address: 209 W. State St, Ithaca 14850
Phone #: 607-277-4341 Fax #:

DESCRIPTION OF INFORMATION:

Patient Name: Bonze Ame Rose Blayk Date of Birth: 5/1/56

Patient Address: 1668 Trumansburg Rd, Ithaca NY 14850

Dates of Service: 9/19/18 – 9/24/18 Date Needed By: _____
(Normal Processing Time if No Date)

INFORMATION TO BE RELEASED:

- ☑ History & Physical
- ☐ Discharge Summary
- ☑ Consultation
- ☑ EKG
- ☑ Occupational/PT
- ☑ ER/Convenient Care
- ☐ Other: _____
- ☑ Laboratory Results/Pathology
- ☑ X-ray Reports ☑ Disc
- ☑ Operative Report
- ☑ Record Abstract
- ☑ Accounting of Disclosure
- ☑ Billing Communication

Includes: (Indicate by Initialing)

- V Alcohol/Drug Treatment
- √ Mental Health Information
- √ HIV/STI-Related Information

REASON FOR RELEASE:

☑ At request of individual ☐ Other: _____

I understand I may revoke this authorization at any time by presenting written revocation to the Health Information Management Department. Revocation will not apply to information already released in response to this authorization. I understand that any release of information carries with it the potential for redisclosure by the recipient and may not be protected by the federal privacy rules. Cayuga Medical Center will not condition treatment, payment, or eligibility of benefits on completion of an authorization. This authorization will expire on (date or event) _____.
If I fail to specify an expiration date or event, this authorization will expire after 6 months. The patient may request a copy of this authorization.

Bonze Blayk 4/5/20
(Signature of patient or legal representative) (Date) (Must be entered or request will be returned)

_____ _____
(Relationship, if other than patient) (Legal Representative Address)

*****Please scan completed form and email to: medicalrecords@cayugamed.org**
or send completed form to the Health Information Department at the address below***