BLAYK, BONZE ANNE ROSE
A00088518428 M000597460
05/01/1956 62 F

Office Use Only:
MR # ____________
Acct. # ____________

ID Checked: ☐ Yes ☐ No
If No checked, why: ____________

AUTHORIZATION FOR RELEASE OF INFORMATION

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

DESCRIPTION OF INFORMATION:

Patient Name: Bonze Anne Rose Blayk
Date of Birth: 5/1/1956
Dates of Service: 9/19/18
Date Needed By: —

INFORMATION TO BE RELEASED:

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

Includes: (Indicate by Initialing)
- ________ Alcohol/Drug Treatment
- ________ Mental Health Information
- ________ HIV/STI-Related Information

☐ Other: ____________

REASON FOR RELEASE:

☐ At request of individual ☒ Other: needs to be notified of release of CMC - altercation

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.

Altered Mental Status
(Signature of patient or legal representative)

(Address)

(Relationship, if other than patient)

(Address)

(Completed by)

(Date)

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 Authorization will be returned to sender with explanation as to what was 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.

*****Please send completed form to Health Information Department*****

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