ORANGE REGIONAL MEDICAL CENTER

Office Use Only

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information from my medical record as described below. This may include medical, psychological, neuro-psychological, psychiatric, drug and/or alcohol abuse information. I understand that this authorization is voluntary.

Patient Name: _____ **Today's Date**: _____

Date of Birth: _____ **Phone Number**: _____

Mailing Address: _____
Street **City/Town** **State** **Zip Code**

Description of information that may be disclosed:

- ◯ Emergency Room Record
- ◯ Inpatient Record
- ◯ Outpatient Record
- ◯ Other

Date(s) of Service: _____

Medical Record Number _____

Organization Providing the Information:

_____

_____

_____

Persons/Organization receiving the information:

□ Orange Regional Medical Center
Department of Radiation Oncology
707 East Main Street
Middletown, NY 10940
Fax: 845-333-9007

1. The information will be used/disclosed for the following purposes: _____
   (NOTE: this item is not required if the disclosure is requested by the patient.)
2. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
3. [If applicable] I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may see or copy the information used/disclosed under this authorization and that I can get a copy of this form after I sign it.
5. I understand that I may revoke this authorization in writing at any time by notifying the providing organization in writing, but if I do it won't affect any actions they took before they received the revocation.
6. I understand this authorization expires on ____/____/____. **If not filled in, authorization will expire in one year.**

_____ _____
Signature of Patient or Personal Representative (**form must be completed before signing**) Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient

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- ☐ Other _____

Date(s) of Service: _____

Medical Record Number _____

Organization Providing the Information:

☐ **Orange Regional Medical Center**
Department of Radiation Oncology
707 East Main Street
Middletown, NY 10940
845-333-2326

Persons/Organization receiving the information:

_____

_____

_____

1. The information will be used/disclosed for the following purposes: _____
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Revised 8.18.16