STEUBEN COUNTY PUBLIC HEALTH
3 E PULTENEY SQUARE, BATH, NY 14810

RELEASE OF INFORMATION FORM

Patient's Name:_____ Date of Birth:_____

Address:_____ Phone #:_____

City/State/Zip:_____

PURPOSE FOR THIS REQUEST:_____

This authorization allows the Steuben County Public Health & Nursing Services to: (check all that apply)

☐ Send copies of your record to (or discuss your information with) the provider/person/facility below

☐ Receive copies of your record from (or discuss your information with) the provider/person/facility below

_____ _____
Name of Provider/Person/Facility Address

_____ _____
City/State/Zip Phone #/Fax # (include area code)

TYPE OF RECORDS/INFORMATION REQUESTED:

☐ History & Physical ☐ Therapy ☐ Discharge Summary ☐ Orders, Progress Notes, etc.

☐ Entire Record ☐ Other, specify:_____

☐ All medical records related to a specific illness or injury:_____
Specify illness/injury

Authorization Valid For: (check one)

☐ This request only.

☐ One year from the date of this authorization OR _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this information.

☐ This request and for medical records of any future treatment of the type described above until:_____(insert date).

I understand that:

- My right to healthcare is not conditional to this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided on the letterhead above, except where a disclosure has already been made in reliance of my prior authorization.
- If the person or facility is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative:_____ Date:_____

Relationship to Patient (if the requestor is not the Patient)_____

Distribution: Original to medical record. Copy to requestor, as required.