



# ORANGE REGIONAL

## MEDICAL CENTER 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.

<b>Patient Name:</b>		<b>Today's Date:</b>	
<b>Date of birth:</b>		<b>Phone Number:</b>	
<b>Mailing Address:</b>			
Street	City/ Town	State	Zip Code
<b>Description of information that may be disclosed:</b>			
<input type="checkbox"/> Emergency Room Record	Date(s) of service:	Medical Record Number	
<input type="checkbox"/> Inpatient Record			
<input type="checkbox"/> Outpatient Record	_____	_____	
<input type="checkbox"/> Other _____			

**Organization Providing the Information:**  
Health Information Management at:

**Persons/Organization receiving the information:**

Orange Regional Medical Center  
707 East Main Street  
Middletown, NY 10940  
Phone: 845-333-1600  
Fax: 845-333-1560

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Phone/Fax

- The information will be used/disclosed for the following purposes: \_\_\_\_\_  
**(NOTE: this item is not required if the disclosure is requested by the patient.)**
- 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.
- [If applicable] I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.
- 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.
- 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.
- I understand this authorization expires on \_\_\_\_/\_\_\_\_/\_\_\_\_. **IF DATE IS NOT STATED, THE 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