

**CONSENT FOR RELEASE
OF INFORMATION**

Patient Name

Date of Birth

Social Security #

Part I - CONSENT TO RELEASE INFORMATION

Extent of Information to be Disclosed

- | | | |
|--|---|---|
| <input type="checkbox"/> Psychosocial | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Physical Workup | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Dates of Treatment |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prognosis | <input type="checkbox"/> Treatment Received |
| <input type="checkbox"/> Entire Chart | <input type="checkbox"/> Other _____ | |

Purpose or Need for Information

TO/FROM: Name, Address and Title of Person/Organization/ Facility/Program
Disclosing Information

SOUTH OAKS HOSPITAL
P.O. Box 426
400 Sunrise Highway
Amityville, NY 11701

TO/FROM: Name, Address and Title of Person/Organization/
Facility/Program to which Disclosure is to be Made

I hereby authorize the release of the above information from my medical record. I understand that this consent may be withdrawn by me at any time except to the extent that the staff/hospital has already taken action in reliance upon it. If not withdrawn, this consent will expire:

when all authorized information has been provided;

(for third party payors), until account is closed.

Other: _____

HIV RELATED INFORMATION (If applicable)

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing this release. You can ask for a list of people who can be given confidential HIV related information without a release form.

When you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

* * *

ALCOHOL/DRUG RELATED INFORMATION

Records of patients treated in alcohol or drug treatment units are protected by Federal Confidentiality Rules (42CFR Part 2).

Signature of Patient	Print Name Signed	Date Signed
Signature of Person Acting for Patient	Print Name Signed	Representative
Signature of Witness	Print Name Signed	Title
		Date Signed

Part II — Cancellation/Refusal To Release Information

I Hereby Cancel My permission to Release Information Indicated in Part I, to the Person/Organization/Facility/Program whose Name and Address is:

I Hereby Refuse to Authorize the Release of Information Indicated in Part I, to the Person/Organization/Facility/Program whose Name and Address is:

Signature of Patient/Person Acting for Patient

Relationship

Date Signed

Signature of Witness

Title

Date Signed

(Use this space if additional room is needed to complete any of the items on the reverse side)

— INSTRUCTIONS —

If the patient is under 18 years of age, only the responsible parent, relative or guardian must sign.

Exception: If patient is a Voluntary Admission on own application, at least 16 years of age but under 18 years of age, only the patient must sign.