mosaic health
Better happens together.

Instructions: Authorization to Obtain Protected Health Information Form

Form B: Authorization to Obtain Protected Health Information

When to use: This form is used when you want copies of your health records for yourself or your child/person that you have guardianship over sent to Mosaic Health.

Instructions:

- **Section 1**: Patient's name, DOB, address and phone number of records requested
- **Section 2**: Add the Name, Address, number and fax number of where the records are that you would like sent to us.

- **Section 3**: Check what health records you want sent to us. Add the dates or the date range of the records you want sent.
  - **If you choose all medical or all dental, you do not have to choose a date range**.
  - Immunizations=vaccinations/shot record
  - Labs=blood work/testing
  - Progress Notes= office visit notes
- **Section 4**: if any of your records that you checked in **Section 3** contain any information regarding mental health conditions, drug/alcohol related conditions and/or HIV/AIDS testing or treatment please **initial** the appropriate boxes so this information can be legally sent to us.
- **Section 5:** Circle the reason you want your records sent to us.
- **Section 6:** Need signature of patient or Legal guardian, date and printed name. Relationship to patient if someone other than patient signed (example: guardian, mother, father)

B

For Internal Use Only: ______________________________________

Printed Name of Mosaic Health Staff receiving completed form

Patient Account Number:_____________ Date___________________

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

1 Patient Name:____Date of Birth: _____________

Address:____Phone Number: ____________

I authorize Mosaic Health to obtain the above patient's records from:

2 Name_______________________________Address_______________________________

City/State/Zip_____________________Phone#_______________Fax#_________________

3 **Choose what records need to be obtained, check below:**

☐ **Entire Medical Record** ☐ **Entire Dental Record** ☐ Medical X-Rays ☐ Dental X-Rays

☐ Lab Results ☐ Medication List ☐ Immunization Record ☐ Progress Notes

Other: ____

For the Following Dates of Treatment:____

(Examples: Specific Date-1/13/2020; Range of Dates- January-July 2019)

***If records include reproductive records of a minor this authorization requires minor signature.**

4 **Specific authorization is required to release the following documentation**

(Indicate by Initialing below, if not initialed information will not be released to us)

____ Alcohol/Drug Treatment ___ HIV/AIDS Related Information ____ Mental Health Treatment

*By specifically authorizing the release of HIV/AIDS related, alcohol or drug treatment, and/or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

*If sending dental x-rays please email to dentalx-ray@mosaichealth.org

5 **The Information is to be requested for the following reason(s):**

☐ Transfer of Care ☐ School/Employment ☐ Disability ☐ Legal ☐ Referral/Care Coordination

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at Mosaic Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires on:_______________(insert date here), or within one (1) year of the date of authorization, whichever is less.

6 ____ ____________________

Signature of Patient/Parent/Legal Representative Date of Signature

______________________________________ ______________________________

Printed Name of Signature Above Relationship to Patient

☐ **Mount Morris**
1 Murray Hill Drive
Building 1, Room 140
Mt. Morris, NY 14510
P:585-243-7840
F: 844-683-9216

☐ **Rushville**
2 Rubin Drive
Rushville, NY 14544
P: 585-554-4400
F: 844-683-9216

☐ **Utica-Medical**
1651 Oneida Street
Utica, NY 13501
P:315-793-7600
F: 844-683-9216

☐ **Utica-Dental**
3 Parkside Court
Building 1
Utica, NY 13501
P: 315-293-7600
F: 844-683-9216

☐ **Lyons**
1519 Nye Road
Lyons, NY 14489
P: 315-871-3178
F: 844-683-9216

☐ **Ilion**
55 Central Plaza,
Suite B
Ilion, NY 13357
P: 315-444-1900
F: 844-683-9216