BURKE
Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

The Winifred Masterson
Burke Rehabilitation Hospital
Member of Montefiore Health System
785 Mamaroneck Avenue, White Plains, NY 10605

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____Date of Birth: _____

Patient Address: _____

Last Four of SSN#: _____ Adm. Date: _____ D/C Date: _____

Phone Number:( ) _____-_____

I authorize The Burke Rehabilitation Hospital, Member of Montefiore Health System to provide and release information with respect to the treatment of the above referenced patient, including, but not limited to information relating to history of illness, social history, diagnostic and therapeutic information including psychiatric, mental illness or drug and alcohol abuse and/or confidential HIV/AIDS related information to:

Name: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

The Purpose of this release of information is for:

Continued Treatment _____ Insurance _____ Attorney _____ Other _____

The information that is to be disclosed should include the following:

History and Physical Exam _____ Discharge Summary _____ Laboratory Reports _____

Radiology Reports _____ MR Abstract _____ Complete Medical Record Copy _____

- Other information to be disclosed: _____
- Please Indicate any information **NOT** to be disclosed: _____
- It is understood that this authorization may be revoked at any time in writing.
- This authorization will automatically **expire** 90 days after the date of the signature appearing below.
- I recognize that the protected health information used/or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.
- This completed authorization form becomes a permanent part of the patient's medical record.
- Fees for copies Patient request; Up to 10 pages are free of charge. Over 10 pages; $0.90 base fee + $0.05 per page. CD's are $6.50. Postage fees apply.
- Payment is expected at time copies are received.
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X _____
Signature of Patient
(or);
X_____ **Date:** _____
Person granting authorization on behalf of the patient, (Supporting Documentation such as Power of Attorney, **must** be included.

Heath Information Management Department (914) 597-2460 (office) (914) 597-2773 (fax)