UNIVERSITY of ROCHESTER MEDICAL CENTER

& Affiliates

Strong Memorial Hospital

Department or Practice HFM - 0891

601 Elmwood Ave., Box# _____
Rochester, NY 14642

Phone (585) 279-4800 Fax (585) 442-8319

SH-48 LawNY **Authorization for Release of Medical Information to LawNY**

Patient Name:_____ Date of birth:_____

Address:_____ Phone:_____

City/State/Zip:_____

This authorization allows URMC and affiliates to:

- Provide Legal Assistance of Western New York (LawNY) with your medical information necessary to successfully complete your legal consultation/case. This could be through a release of records and/or discussion between your medical provider and LawNY attorney.
- Receive your legal consultation/case information from LawNY. This could be through a release of records and/or discussion between your medical provider and LawNY attorney.

Purpose of this request: Legal consultation/case

Authorization valid until: Current LawNY legal consultation/case is closed

I understand that:

- I will receive medical treatment whether or not I sign this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed, except that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.

Signature of patient or representative:_____ Date:_____

Relationship to patient (if representative):_____

Distribution. Original to medical record. Copy to patient as required
This authorization must be retained for a minimum of six years beyond the validation limits