ENH
EASTERN
NIAGARA
Hospital

Request for Medical Records

Adults treated by Eastern Niagara Hospital since 2016 and pediatric patients treated by Eastern Niagara Hospital since 2001 may obtain a copy of their medical records. To obtain a copy of your medical records, please complete, sign and date the following ***Authorization for Release of Health Information.*** Return the completed form in a sealed envelope to maintain confidentiality to: **Eastern Niagara Hospital, Attn: Medical Records Dept., 521 East Ave, Lockport, NY 14094** or send by secure fax to: 716-514-5786.

There is an administrative charge for this service. A member of the Medical Records department will contact you with the charge for your records at the daytime number you provide on the ***Authorization***. Please allow 30 days for completion of your request.

Please note: Your Eastern Niagara Hospital medical records maintained by Health*e*Link, a permanent, independent medical portal will continue to be accessible by your Western New York Primary Care Provider.

Thank you.

ENH Medical Records

716-514-5800 ext. 3728

ENH

Eastern Niagara Hospital

☐ Lockport
521 East Avenue
Lockport, NY 14094

☐ Niagara Regional Surgery Center/Imaging Center
5875 S. Transit Road
Lockport, NY 14094

☐ WNY Occupational Medicine
☐ Express Care

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		Telephone number:

I, or my authorized representative, request that health information regarding my care and treatment be released by **EASTERN NIAGARA HOSPITAL** as specified on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information in relation to **ALCOHOL and DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, (except psychotherapy notes), and **CONFIDENTIAL HIV RELATED INFORMATION** if I place my initials on the appropriate line in item 6. In the event the health information described below includes any of these types of information, and I initial the line in the box in Item 6, then I specifically authorize release of such information to the person(s) indicated in Item 5.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2 above, and this re-disclosure may no longer be protected by federal or state law.

5. Name and address of entity/person(s) to whom this information will be sent:

6. Specific information to be released:

__ Medical Record from (insert date) _____ to (insert date) _____

__ Entire Medical Record, including patient history, progress notes, discharge summary, test results, radiology reports and consults.

__ Radiology Reports: _____
__ Emergency Room Record: _____
__ Lab Reports: _____
__ Billing records: _____
__ Other: _____
_____

Include: (indicate by initialing)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

7. Reason for release of information: ___ At request of individual ___ Other: _____	8. Date on which this authorization will expire:
9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered.

_____ _____

Signature of patient or representative authorized by law — Date

Rev. 11/22

HIPAAREL