

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		Patient Phone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth 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 relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, expect psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal state or law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without my authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. Name and address of health provider or entity TO RELEASE this information:
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7. Name, address and phone/fax number of person(s) or category of person TO WHOM THIS INFORMATION WILL BE SENT:
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If records are more than 25 pages, please mail records or send CD.

8(a). Records requested:	Include: <i>(Indicate by Initialing)</i>
<input type="checkbox"/> Last 2 years records unless otherwise indicated here for ALL records: <input type="checkbox"/> <input type="checkbox"/> Specific information to be released: _____	_____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

8(b). Choose one if appropriate:	8(c). <u>Purpose of Disclosure</u>	Fee: (must be checked)
<input type="checkbox"/> Patient transferring - Complimentary first copy, sent to new provider <input type="checkbox"/> Continuity of Care to Specialist (no charge)	<input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Patient's personal use	<input type="checkbox"/> Paper copies 75¢ per page <input type="checkbox"/> CD \$6.50 fee <input type="checkbox"/> Uploaded to patient portal- no fee

10. Date or event on which this authorization will expire:
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11. If not the patient, name of person signing form:	12. Authority to sign on behalf of patient:
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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

***Human Immunodeficiency Virus that cause AIDS. The New York State Public Health Law protects information which reasonably could identify someone has having HIV symptoms or infection and information regarding a person's contacts.**