AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name:	**Date of Birth:**	**S.S. NO.**:
Patient Address:		

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 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/DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9a. 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 9a, I specifically authorize release of such information to the person(s) indicated in item 8.

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 sate law. I understand that I have a right to request a list of people who may receive or use my HIV related information without 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 re-disclosed by the recipient (except as noted above in Item 2) and this re-disclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9a. Specific information to be released: **Date of Accident:**

☐ Entire **medical - hospital records and itemized billing**
_____
(*including doctor/nurse notes, operative reports, admission/discharge, ambulance report, radiological (x-ray, CT Scan, MRI, etc.) reports*
☐ **Radiological reports and itemized billing** (X-Ray, MRI, CT Scan)
of_____
☐ **Diagnostic** lab results _____
☐ **Physical therapy records and itemized billing** _____
☐ **Other**_____
_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug ____Mental Health Information
_____ HIV Related Information

Authorization to Discuss Health Information

b. ☐ By initialing here _____ I authorize _____
Initials Name of Individual health care provider

to discuss my health information with my attorney or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ For purposes of litigation ☐ For personal use ☐ Other:_____	11. Date or event on which this authorization will expire
12. If not the patient, name of the person signing the form:	13. Authority to sign on behalf of patient:

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.

_____ Dated: _____
Signature of Patient:

Sworn to before me on _____

_____
Notary Public

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