



56-45 Main Street, Flushing, NY 11355

Health Information Management Department 718-670-1090

Medical Record # _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name (last name, first name, middle initial)	Date of Birth	Social Security Number
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Patient Address	Telephone Number
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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:

- This authorization may include disclosure of information relating to **ALCOHOL** and **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 9(a). In the event that health information described below includes any of these types of information, and I initial the line on the box in item 9(a), I specifically authorize release of such information to the person(s) indicated in item 8.
- 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 or state law. I understand that I have the 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.
- I have the right to revoke this authorization at any time by writing to the health care provided listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 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.
- 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.
- 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 care provider or entity to release this information;

8. Name and address, telephone and/or fax number of person or category of person to whom this information will be sent:

9(a). Specific information to be released:

- Medical Record from (insert date) _____ to (insert date) _____
- Medical Record Abstract, may include discharge summary, operative report, history and physical, lab and radiology results
- Entire Medical Record, may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, monitoring strips, referrals, consults, billing records, insurance records.

Other _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**
_____ **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:

- At request of individual
 Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing 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 this form and am aware of the \$.75 per page fee.

Signature of patient or representative authorized by law.

Date: _____