AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____
Address: _____
Patient Phone Numbers: _____

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 (HIPPA). I understand that:
1. 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 8. 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, I specifically authorize release of such information to 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 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 of disclosure of HIV-related information, I may contact New York State Division of Human Rights at (212)-480-2493 or the Buffalo Division of Human Rights at (716) 847-7632 located at Main Place Tower, 350 Main Street, 10th Floor, Suite 1000B, Buffalo, NY 14202
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.

Release My Medical Record:
6. From (Who is to Release the Information):

7. To (Who is to Received the Information):

8. Specific information to be released (please select all that apply):
☐ Medical Records from _____ to _____
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), **Immunization records**, test results, radiology studies, films, referrals, consults, records sent to you by other health care providers,
☐ Other:

Include:
☐ **Alcohol/Drug Treatment:** (Initials) _____

☐ **Mental Health Information:** (Initials) _____

☐ **HIV-Related Information:** (Initials) _____

9. Reason for release of information:
☐ At request of individual
☐ Other:

10. If not patient:
Name and relationship of person signing form:

11. Date authorization expire: _____ or one year from when the authorization was signed

_____ _____
Signature of patient or representative **Date**

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.