DT40072

UPSTATE
UNIVERSITY HOSPITAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

(This form has been approved by the New York State Department of Health)

Patient Address: _____ Telephone 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, 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 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 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. This agency is 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 conditions upon my authorization of this disclosure.
5. Information disclosed under this authorization might be disclosed 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:

7. Name and address of person(s) to whom this information will be disclosed:
   a) _____
   b) _____
   c) _____

8. Specific information to be disclosed:
   ☐ Complete copy of Medical Record **OR** check all that apply:
   ☐ discharge summaries ☐ office notes (except psychotherapy notes) ☐ test results ☐ radiology reports ☐ x-ray films
   ☐ billing records ☐ Other: _____.
   Copies of Medical Record for Dates of Service From: (insert date) _____ to (insert date) _____.
   Include: *(Indicate by Initialing)* _____ **Alcohol/Drug Treatment**
   _____ **Mental Health Information** _____ **HIV-Related Information**

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

10. This authorization will expire upon:
    ☐ Revocation
    ☐ Date/Event: _____
    ☐ One Time Release

11. If not the patient, name of person signing form:

12. 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.

_____ Date: _____

Signature of patient or representative authorized by law

* 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.