

## Authorization for Release of Health Information

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

<b>1. Contact information of health care provider or entity to release this information:</b>		
Name:	Address:	
Phone #:		
<b>2a. Contact information of person(s) or entities who will receive this information:</b>		
Name:	Address:	
Phone #:	Fax:	E-mail:
<b>2b. Method of delivery for release of information:</b>		
<input type="checkbox"/> Pick-up at facility <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> USB Flash Drive <input type="checkbox"/> E-mail (to have sent by unencrypted E-mail complete page 3)		
<input type="checkbox"/> Verbal _____ <b>PLEASE INITIAL HERE</b> to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.		
<input type="checkbox"/> Other method of delivery (please explain): _____		
<b>3a. Specific information to be released:</b>		
<input type="checkbox"/> Medical Record Abstract (summary of record)		
<input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____		
<input type="checkbox"/> Entire Medical Record		
<input type="checkbox"/> Laboratory results for date of service _____		
<input type="checkbox"/> Other: _____		
<b>3b. The following types of information will NOT be released unless you or your authorized representative initial in the appropriate spaces provided below:</b>		
_____ Substance Abuse Treatment Information (including diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)		
_____ Mental Health Treatment Information		
_____ HIV-Related Information		
<b>4. Reason for release of information:</b>		
<input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____		

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5. I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- a. I have the right to revoke this Authorization and my Permission to Send Information Requested by Unencrypted E-mail (page 3 of this document) at any time by writing to the health care provider listed in Section 1. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.
- b. 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.
- c. Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

6. Date or event on which this Authorization will expire (this field must be completed with a date or event):

7. Patient/Agent/Surrogate/Guardian\* (Signature):

8. Date:

9. Printed name of person signing this form:

10. Authority to sign on behalf of patient or relationship to patient (if applicable):

\*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Only for use when interpreter services are utilized for the completion of this form:

\_\_\_\_\_  
 Telephonic Interpreter's ID # Date/Time

OR

\_\_\_\_\_  
 Signature: Interpreter Date/Time

\_\_\_\_\_  
 Print: Interpreter's Name and Relationship to Patient

\_\_\_\_\_  
 Witness to Signature

\_\_\_\_\_  
 Print Witness Name

\*\*\*Patients requesting information by unencrypted E-mail must complete "Permission to Send Information Requested by Unencrypted E-mail" (Form# VD001E).

