THE NEW YORK HOTEL TRADES COUNCIL
HEALTH CENTER, INC.
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

AUTHORIZATION FORM
REQUEST FOR RELEASE OF MEDICAL RECORDS

This Authorization, if signed by you, will allow for the sharing of information between your healthcare providers and/or health plans.

Patient's Name_____ Date of Birth_____
Address _____
MRN/SS#_____ _____
Phone Number _____

Request for Release of Protected Health Information (PHI)

I hereby request that my medical records be released to: MetroPlus Health Plan, Inc., located at 160 Water Street, 3rd Floor, New York, NY 10038 and my primary care physician of choice.

Note, your medical records may be transmitted via the electronic health information exchange.

PHI to be Released (please check the applicable box(es))

□ Medical Record from (insert dates) _____ to _____

□ **Include the following (indicate by initialing at each line for the information type you wish to have released)**

_____ Alcohol/Drug Related Treatment _____ Mental Health Information _____ HIV-Related Information

This Authorization is voluntary. I understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be affected if I do not sign this form. I understand that if I initial above, information released may be related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. I also understand that information under this Authorization may be disclosed by the recipient and may no longer be protected by federal and state laws. I may revoke this Authorization at any time by notifying HCI in writing, but I understand that if I do revoke this Authorization, such revocation will not have any effect on any actions HCI may have taken before it received the revocation. In other words, I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

This Authorization will automatically expire on December 31, 2021, or on the following date that I designate:
_____

I hereby authorize the use or disclosure of my PHI as described above. I understand that my PHI will be released at my request and authorization.

_____ _____ _____
Signature of Patient OR Patient's Personal Representative Date Time

_____ _____
Print Name Relationship to Patient

Please submit this Form electronically to HIM@hotelfunds.org