



## HIPAA AUTHORIZATION TO OBTAIN PHI FROM EXTERNAL PROVIDERS

Patient Name	Date of Birth:	Telephone Number
Patient Address:		

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/DRUG TREATMENT, MENTAL HEALTH TREATMENT except psychotherapy notes, GENETIC TESTING, and CONFIDENTIAL HIV\* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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 or the New York City Commission of Human Rights at (212) 306-7450. 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.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY, GOVERNMENTAL AGENCY OR HEALTH CARE PROVIDER SPECIFIED IN ITEM 9 (b)

7. Name, address, telephone and fax numbers of health provider or entity to release this information:
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8. Name and address of person(s) or category of person to whom this information will be sent: <b><u>NYHTC / HANYS Health Center, Inc. 265 Ashland Place, Brooklyn NY 11217/ Fax: 212-237-3008/ e-mail: HIM@hotelfunds.org</u></b>
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9(a). Specific information to be released:
<input type="checkbox"/> Entire Medical Record from (insert date) _____ to (insert date) _____ including patient histories, office notes (except psychotherapy notes), test results, radiology studies, images/films, referrals, consults, and records sent to you by other health care providers and used by your entity for continuation of my care. <input type="checkbox"/> Billing records, insurance records. <input type="checkbox"/> Other: _____
Include: (Indicate by Initialing) <input type="checkbox"/> Alcohol/ Drug Treatment <input type="checkbox"/> Mental Health Information <input type="checkbox"/> HIV-Related Information <input type="checkbox"/> Genetic Testing Information

<b>Authorization to Discuss Health Information</b> (b) <input type="checkbox"/> By initialing here _____ I authorize _____ to discuss my health information with my attorney, governmental agency or health care provider, listed here: <b><u>NYHTC/HANYS Health Center, Inc.</u></b>
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10. Reason for release of information: <input type="checkbox"/> <b>At request of individual</b> <input type="checkbox"/> Other: _____	11. Date or event on which this authorization will expire:
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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
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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.

\*Adapted from OCA Official Form No.: 960, NYS DOH