



## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]		
me l	Date of Birth	Social Security Number
dress	Canadanan galaman galaman dan dan dan dan dan dan dan dan dan d	
horized representative, request that health information regarding	my care and treatmen	t be released as set forth on this form
ce with New York State Law and the Privacy Rule of the Health	Insurance Portability a	and Accountability Act of 1996
I understand that:		
horization may include disclosure of information relating to NT, except psychotherapy notes, and CONFIDENTIAL HIV*	ALCOHOL and DR	UG ABUSE, MENTAL HEALT
nate line in Item 9(a). In the event the health information descrine on the box in Item 9(a), I specifically authorize release of such authorizing the release of HIV-related, alcohol or drug treatme from redisclosing such information without my authorization that I have the right to request a list of people who may receive or discrimination because of the release or disclosure of HIV-rela Rights at (212) 480-2493 or the New York City Commission for protecting my rights, he right to revoke this authorization at any time by writing to the authorization except to the extent that action has already been tall tand that signing this authorization is voluntary. My treatment and the conditioned upon my authorization of this disclosure, ion disclosed under this authorization might be redisclosed by may no longer be protected by federal or state law.  UTHORIZATION DOES NOT AUTHORIZE YOU TO DISCHANYONE OTHER THAN THE ATTORNEY OR GOVE	bed below includes and information to the pent, or mental health to unless permitted to or use my HIV-related ted information, I may of Human Rights at the health care provider ken based on this authort, payment, enrollmethe recipient (except	by of these types of information, and erson(s) indicated in Item 8. reatment information, the recipient do so under federal or state law. information without authorization. A contact the New York State Division (212) 306-7450. These agencies a listed below. I understand that I materization, and in a health plan, or eligibility for as noted above in Item 2), and the HINFORMATION OR MEDICA
I address of health provider or entity to release this information:  I address of person(s) or category of person to whom this information.	ntion will be sent:	17 TO THE OWN AND A STATE OF THE OWN AND A ST
ic information to be released: lical Record from (insert date) to (insert	doto)	
to (insert date) to (insert date) to (insert date) to (insert de Medical Record, including patient histories, office notes (exce	nt psychotherapy note:	s) test results radiology studies film
rrals, consults, billing records, insurance records, and records ser	nt to you by other heal	th care providers.
er:		ndicate by Initialing)
		Alcohol/Drug Treatment
· · · · · · · · · · · · · · · · · · ·		Mental Health Information
on to Discuss Health Information		HIV-Related Information
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Initials Na	me of individual health o	care provider
uss my health information with my attorney, or a governmental a		,
(A66	igency, listed here:	
(Attorney/Firm Name or Governmental for release of information:	gency, nated nete.	
quest of individual	Agency Name)	ic authorization will avaisa.
· [:	Agency Name)	is authorization will expire:
	Agency Name)	is authorization will expire:
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	Agency Name) e or event on which th	

\* 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.

Signature of patient or representative authorized by law.