AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

Patient Name	**Date of Birth**	**Social Security Number**
Street Address	**City/State**	**Zip Code**

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 (HIPPA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, 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 information without authorization. If I experience discrimination because of the release or disclosure of this 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 conditions 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 PERSON(S) OR ORGANIZATION(S) SPECIFIED IN ITEM 9(b).**

7. **Name and address of health provider or entity to release this information:**

8. **Name and address of person(s) or category of person to whom this information will be sent:**

9(a). Specific information to be released:

☐ Mental Health Record (insert date): ______________________ to (insert date): ______________________

☐ Other: ______________________
____

Include: (Indicate by initialing)
________ All psychotherapy notes
________ HIV-Related Information
________ Alcohol/Drug Treatment

Authorization to Discuss Health Information:

(b) ☐ By initialing here ____________, I authorize ______________________
(Initials) (Name of individual health care provider/agency)

to discuss my mental health information with ______________________
(Name of individual health care provider/agency)

10. Reason for release of information: ☐ At request of individual ☐ Other: ______________________	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Relation to 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 this form.

______________________ Date: ______________________
Signature of patient or representative authorized by law.