Montefiore Authorization for Release of Health Information Pursuant To HIPAA

Patient Name and Address (Print)	Date of Birth	MRN
	Telephone Number	Date Received at Facility

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed 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** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, 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, drug treatment, or mental health related 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 OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

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

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

9 a) **Specific information to be released:**

☐ Dates of Service(s): from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes *(except psychotherapy notes)*, test results, radiology studies, films, referrals and consults.

☐ Medical Record Abstract

☐ Other: _____

_____

_____

Include: (Indicate by initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Related Information**

_____ **HIV-Related Information**

_____ **Genetic Testing Information**

Please note, unless applicable line is initialized, we may be unable to process your request

9 b) **Authorization to Discuss Health Information**

☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with the individual listed: _____ (Individual Name)

10. Requested format for Delivery:	11. Mode of Delivery:
☐ Paper ☐ CD ☐ Other: _____	☐ Pick up ☐ Mailed ☐ Other: _____
12. Reason for release of information: ☐ At request of individual ☐ Other: _____	13. Date or event on which this authorization will expire:
14. If not the patient, name of the person signing form (Print):	15. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted all of the above.

_____ _____

Signature of patient or representative authorized by law — Date

Please return completed form to: Montefiore, 111E. 210th Street, Bronx, NY 10467
Attn: Medical Records (HIM)