AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

	Date of Birth	Medical Record Number
Patient Address	I	
or my authorized representative, request that	health information regarding my ca	are and treatment as set forth on this form:
HIPAA), I understand that: . This authorization may include disclosure of FREATMENT, except psychotherapy notes, a	f information relating to ALCOHO and CONFIDENTIAL HIV* REL	Insurance Portability and Accountability Act of 199 L and DRUG ABUSE, MENTAL HEALTH ATED INFORMATION only if I place my initials on
nitial the line on the box in Item 9(a), I specifical. If I am authorizing the release of HIV-related prohibited from redisclosing such information what I have the right to request a list of people will be under the release of the release or disclosed Rights at (212) 480-2493 or the New York City	cally authorize release of such informed, alcohol, or drug treatment, or mustification unless per who may receive or use my HIV-related information, I may be sure of HIV-related information, I may be sure of HIV-related information.	low includes any of these types of information, and I rmation to the person(s) indicated in Item 8. Hental health treatment information, the recipient is rmitted to do so under federal or state law. I understand ated information without authorization. If I experience hay contact the New York State Division of Human (212) 306-7450. These agencies are responsible for
evoke this authorization except to the extent	that action has already been taken l	care provider listed below. I understand that I may based on this authorization. at, enrollment in a health plan, or eligibility for benefits
vill not be conditioned upon my authorization. Information disclosed under this authorization edisclosure may no longer be protected by fed	of this disclosure. on might be redisclosed by the reciperal or state law.	pient (except as noted above in Item 2), and this
		MY HEALTH INFORMATION OR MEDICAL IENTAL AGENCY SPECIFIED IN ITEM 9 (b).
7. Name and address of health provider or en	tity to release this information:	
8. Name and address of person(s) or category	of person to whom this information	n will be sent:
9(a). Specific information to be released: ☐ Medical Record form (insert date) ☐ Entire Medical Record, including patien films, referrals, consults, billing records, ☐ Other:	, insurance records, and records sen Include: (Alcohol/	chotherapy notes), test results, radiology studies,
	HIV-Re	elated Information c Testing
Authorization to Discuss Health Information (b). By initialing here I authorize	HIV-Ro Genetic	
Authorization to Discuss Health Information (b). By initialing here I authorize _	HIV-Re Genetic	c Testing
Authorization to Discuss Health Information (b). By initialing here I authorize _ Initials Name of ind	HIV-Re Genetic	c Testing
Authorization to Discuss Health Information (b). By initialing here I authorize _ Initials Name of ind to discuss my health information with my	HIV-Re Genetice attorney, or a governmental agency mental Agency Name)	c Testing

* 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.

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Signature of Patient or representative authorized by law.