

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security 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.

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 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 OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b)

7. Name and address of health provider or entity to release the information <i>UBMD Obstetrics & Gynecology, 6645 Main Street, Suite B, Williamsville, NY 14221</i>
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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: <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, and records sent to you by other health care providers <input type="checkbox"/> Other: _____	Include: <i>(Indicate by Initialing)</i> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information
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Authorization to Discuss Health Information	
(b). By initialing here _____, I authorize _____	
Initials	Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:	
_____ (Attorney/Firm Name or Governmental Agency Name)	

Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	Date or event on which this authorization will expire:
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If not the patient, name of person signing form:	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.

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