☐ Kenmore Mercy Hospital 2950 Elmwood Ave. Kenmore NY 14217 716-447-6116	☐ Sisters of Charity Hospital Main St. Campus 2157 Main St. Buffalo NY 14214 716-862-1986
☐ Mount St. Mary's Hospital and Health Center 5300 Military Road, Lewiston, New York 14092 716-298-2230	☐ Sisters of Charity Hospital St. Joseph Campus 2605 Harlem Rd. Cheektowaga NY 14225 716-891-2157

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please note:

There no charge for records being released to a doctor or hospital. All other requests for paper records will be charged a fee of $.75 per page copied. Medical records if available and requested in electronic format are subject to a nominal fee. Paper copies can be picked up in the Health Information Department 8am-4pm Monday –Friday or will be mailed to you upon request. ☐ Documents to be picked up ☐ Mail to address below.

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____ Telephone #: (_____) _____

Date(s) of Treatment: _____
Type(s) of Treatment: _____

This form authorizes the provider to disclose the following specific health information to the recipient

From: _____
(Name/Department/Address of Disclosing Facility of Person)

To: Name/Department _____

Address/E-mail/Fax of Facility or Person Receiving the Information _____

Disclose as: ____ paper record ____ fax (info provided above) ___ email (info provided above) ____ Electronic storage device USB (only available if record is in electronic format)
____ direct electronic access (only available to CHS approved individuals and entities) ____ Verbal disclosure

*****Note: Authorization for direct CHS electronic medical record access will <u>not</u> restrict access or disclosure to the minimum necessary.**
Therefore information on HIV, drug and alcohol treatment, and mental health notes if present may be accessed and disclosed.

Information Requested: Provide date(s) of service _____

_____ Entire Record _____ Discharge Summary _____ Operative Report ___ Physician's Notes ___ X-Ray
_____ Face Sheet _____ History & Physical _____ Pathology Report ___ Laboratory ____ clinical letter
_____ Discharge Instructions Other: _____

This authorization is granted for the following purpose(s): _____

This authorization is valid until ____/____/____ or until the occurrence of the following event: _____

Or, **<u>in any case not to exceed one year</u>**.

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations. **<u>However, in the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies</u>:** THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CRF PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I am signing this authorization voluntarily.

Only ***ONE*** of the following sections must be completed.

This section is to be completed if authorization is being given by the Individual:

_____ _____
Signature of Individual Date Signed

This section is to be completed if authorization is given by a Personal Representative:

_____ _____
Name of Personal Representative: Signature of Personal Representative

_____ _____
Date Signed Description of Authority to act as personal Representative of the Individual (e.g., Guardian, Attorney, Health Care Agent)

This form authorizes release of medical information including HIV-related information. You may choose to release only your non-HIV medical information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under NY State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of healthand/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, healthinformation and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your healthinformation must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV medical information **
- ☐ Both (non-HIV medical and HIV-related information)

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released:_____

_____

Describe information to be released:_____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized From: _____ To: _____

Exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

_____

_____

_____

_____

Please sign below ONLY if you wish to authorize all facilities/persons listed on pages 2, 3 (and 4 if used) of this form may share information among and between themselves for the purpose of providing healthcare and services. Please sign below to authorize.Signature _____ Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general healthand/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 2:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general healthand/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 2:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights at 1-888-392-3644 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page twoto release healthand/or HIV-related information of the person named on page two to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number_____

Complete information for each facility/person to be given general health information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines may be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 2:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general health and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 2:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general heath and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 2:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

If any/all of this page is completed, please sign below:

Signature _____ Date _____

(Subject of information or legally authorized representative)

Client/Patient Number_____

This Authorization (pages 2-4) for the Release of Health Information and Confidential HIV-Related Information is HIPAA compliant. If releasing only non-HIV related health information you may use page 1- Authorization for Disclosure of Health Information.