St Francis Hospital
100 Port Washington Blvd.
Roslyn, NY 11576
(516) 562-6085

FOR FACILITY USE ONLY:
Date Received: _____
Date Processed: _____
Logged By: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Last Four (4) Digits of SS#
Patient Address	Phone Number	MR#

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 (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* INFORMATION** only if I place my initials on the appropriate line in Item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 7.

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. Name and address of health provider or entity to release this information:
ST FRANCIS HOSPITAL, 100 PORT WASHINGTON BLVD., ROSLYN, NY 11576, (516) 562-6085

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

8. Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record

☐ Other: _____

_____

_____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **HIV Related Information**

_____ **Mental Health Information**

9. Reason for release of information:
☐ Personal Use ☐ Medical Care ☐ Attorney
☐ Insurance ☐ Other:

10. This authorization will expire within 1 year of the signature date unless specified:

11. If not the patient, name of person signing form:

12. Authority to sign on behalf of 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 the form.

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

A <u>COPY</u> of this Authorization shall have the same force and effect as an original

*** 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.**