AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I, or my authorized representative, hereby authorize Easy Choice Health Plan of New York and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

1. Member Information

Name:		**Member ID:**
Street Address:		**Birth Date:**
City:	**State:**	**Zip:**
Telephone:	**Email:**	

2. Authorized designee to receive PHI/ Insurance Record pertaining to the Member Identified above:

Last Name	**First Name**		**Daytime Telephone Number**
Street Address	**City**	**State**	**Zip**
Relationship to Member (if Attorney, Law Firm or Government Agency, please indicate here name here)			

In accordance with New York State Law and 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 3. 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 3, I specifically authorize release of such information to the person indicated in Item 2.
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 Easy Choice Health Plan of New York. 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 Easy Choice Health Plan of New York, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in #2 above), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN ITEM 2.**

3. Specific Information to be released:

If you only wish to release Medical Records within a certain date range, indicate here: from (insert date) _____ to (insert date) _____

☐Entire Medical Record, including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to Easy Choice Health Plan of New York by health care professionals, insurers, other such health care providers

☐Or Other:

_____

_____

_____

_____

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Member or representative authorized by law Date

*HIV (Human Immunodeficiency Virus) that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone having HIV symptoms or infection and information regarding a person's contacts.