

ITHACAMED ADAM LAW, MD, PC

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. PATIENT NAME:	2. DATE OF BIRTH: / /
3. ADDRESS: _____ PHONE: () _____ - _____	

I, or my legally authorized personal representative, request that health information regarding my care and treatment be disclosed as set forth on this form. In accordance with New York State law and the Privacy Rule of the Health Information Portability and Accountability Act (HIPAA) of 1996, I understand that:

- 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 box 5 below. In the event the health information described below includes any of these types of information, and I initial the items in box 5, I specifically authorize disclosure of such information to the person or persons indicated in box 6B. If I am authorizing the disclosure of HIV-related, alcohol or drug treatment, or mental health treatment information, that recipient is prohibited from redisclosing such information about 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 believe my rights have not been protected, I may contact the New York State Division of Human Rights at 212.480.2493.
- This authorization is voluntary and I have the right to refuse to sign it. My treatment will not be conditioned upon my authorization of this disclosure.
- I have the right to revoke this authorization at any time by writing to the healthcare 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.
- Information disclosed might be redisclosed by the recipient except as noted above, and this redisclosure may no longer be protected by Federal or state law.
- This authorization does not authorize you to discuss my health information or medical care with anyone other than the person or persons specified below in box 6.
- I may be charged a fee of up to \$0.75 per page if I am requesting a copy of my records for my own personal use.

4. I authorize the disclosure of health information of the individual named above for the following purpose:

<input type="radio"/> for medical care	<input type="radio"/> to discuss care with _____
<input type="radio"/> for insurance purposes	Relationship: _____ Phone: _____
<input type="radio"/> to transfer care to another healthcare provider	<input type="radio"/> other: _____

5. The type of information to be disclosed is as follows. Please check the appropriate items below:

<input type="radio"/> immunization records	Include (indicate by initialing) _____ Alcohol / Drug Treatment _____ Mental Health Information _____ HIV-Related Information
<input type="radio"/> lab and/or x-ray results	
<input type="radio"/> entire health record (last two years unless otherwise noted)	
<input type="radio"/> other, please describe: _____	

6A. Please disclose the information above **FROM**

ITHACAMED, ADAM LAW, MD, PC | FAX 607.277.3242

NAME/ORGANIZATION: _____

Address: _____

City: _____ STATE: _____ ZIP: _____

Phone: () _____ - _____ Fax: () _____ - _____

6B. Please disclose the information above **TO**

ITHACAMED, ADAM LAW, MD, PC | FAX 607.277.3242

NAME/ORGANIZATION: _____

Address: _____

City: _____ STATE: _____ ZIP: _____

Phone: () _____ - _____ Fax: () _____ - _____

7. Select one of the following two choices:

This authorization will expire on the following date: ____/____/____

This authorization will expire when the following event happens. The event must relate to the individual or the purpose of the authorized disclosure.

Describe the event: _____

8. **X** _____ Date _____

Signature of patient or personal representative authorized by law

If personal representative, relationship to patient (please print)

FOR OFFICE USE ONLY:

_____ Action taken _____

_____ Employee signature _____ Date _____