

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA – NY & NJ

Patient Name	Date of Birth	Medical Record 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: In accordance with applicable 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; **CONFIDENTIAL HIV/AIDS-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/AIDS-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 the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact federal and state agencies responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to Summit Health CityMD. 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 consulting providers, my primary care doctor, or other individual specified in Item 9(b).**

7. Name and address of health provider or entity to release this information: Summit Health CityMD Email: MedicalRecords@citymd.net Fax: (908) 934 9383	
8. Name and address of person(s) or category of person to whom this information will be sent:	
9(a). Check the Practice that applies: ___ CityMD ___ First Med ___ Premier Care ___ STAT Health ___ Franklin (FIMC) ___ Summit Med Grp Other: _____	
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, insurance records, and records sent to you by other health care providers.	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Include (indicate by initialing): _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV/AIDS-related Information	
9(b). Authorization to Discuss Health Information:	
By initialing here _____ I authorize Summit Health CityMD to discuss my health care with consulting providers, my primary care doctor, and _____. (Name of Individual)	
10.Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. 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 with a copy of the form.

Signature or representative authorized by law: _____ Date: _____

NYS: Human Immunodeficiency Virus that causes AIDS. The NYS Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person’s contacts.