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Phoenix, New York 13135
Phone: 315- 695-4700 Fax: 315- 695-4706

THIS SECTION IS FOR OFFICE USE ONLY
 Date Received _____
 Date Completed _____
 By _____

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name (Include any Maiden names &/or Alias)	Date of Birth	Medical Record Number
Patient Address	SS#	Phone Number

- I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:
- This authorization may include disclosure of information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS related information only if I place my initials on the appropriate line in item 9. 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, I specifically authorize release of such information to the person(s) indicated in Item 7.
 - With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug, Substance Use Disorder treatment (SUD), or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS/SUD/MH related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
 - I have the right to revoke this authorization at any time by writing to the provider listed below in Item 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signed this form.
 - Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
 - Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in Item 2), and this re-disclosure may no longer be protected by federal or state law. I understand that in compliance with New York State statute, I shall pay a fee of \$.75 per page or \$3.00 (whichever is less). There is no charge for referral care or follow up treatment.

6. Name, Phone Number, Fax Number, and Address of Provider or Entity to Release this Information:

7. Name, Phone Number, Fax Number, and Address of Person(s) to Whom this Information Will Be Disclosed:

8. Reason for Release of Information:
 Changing Primary Care Physician Specialist/Referral/Continuity of Care Legal or Insurance purposes Other: _____

9. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____
INSERT START DATE INSERT EXPIRATION DATE OR EVENT

All health information (written and oral), except: _____

Only the following specific information: _____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
	<input type="checkbox"/> Records from alcohol/drug treatment programs	
<input type="checkbox"/> Clinical records from mental health programs*		
<input type="checkbox"/> HIV/AIDS related Information		

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

11. Authority to sign on behalf of patient: _____

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

 SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

 WITNESS SIGNATURE DATE

This form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.