ConneXtCare
A Community of Care

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Oswego, New York 13126
Phone: 315-342-0880 Fax: 315-593-6195

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:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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) for paper copies. There is no charge for referral care of 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:_____ (INSERT START DATE) until _____ (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
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ 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.