Hematology-Oncology Associates of CNY, P.C.
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Authorization for Release of Health Information

This form is approved by the NYS DOH

Patient Name	Date of Birth
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 New York 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, CONFIDENTIAL HIV* RELATED INFORMATION, and MENTAL HEALTH RECORDS only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes this type of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.

2. If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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 the health care 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.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditions upon my authorization of this disclosure.

5. Information disclosed under this authorization might be disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

6. This Authorization allows Hematology Oncology Associates of CNY to:

☐ SEND copies of my record to (or discuss information with) the provider/person/facility below

☐ RECEIVE copies of my record (or discuss information with) the provider/person/facility below

_____ , _____

_____, _____

_____, _____

7. Specific information to be released: *(Indicate by Initialing)*

__X___ Entire Medical Record, including but not limited to patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records provided to us by you or other health care providers.

_____Other Specific Records: _____

_____ **Alcohol/Drug Treatment**

_____ HIV Related Information (Authorization valid From_____ To_____)

_____ Mental Health Records (Authorization valid From _____To _____)

_____Genetic Testing (Authorization valid From _____To _____)

8. Reason for release of information:

_____ At the request of individual _____ Other: _____

9. If not the patient, name of person signing form:	10. 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 a copy of the form. I understand that I have the right to revoke this authorization at any time by written notice, except to the extent disclosure has already been made in reliance on this authorization.

_____ _____ _____

Signature of patient or patient representative authorized by law. Date Expiration Date

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

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