Authorization for Release of Health Information

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

1.

Contact information or health care provider or entity to release this information (from who):	
Name:	Address:
Phone #:	

2.

Contact information of person(s) or entities who will receive this information (to who):		
Name:	Address:	
Phone #:	Fax:	E-mail:

3.

Manner	**Form/Format**	**Delivery Details**
☐ Regular Mail	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD	Mailing Address:
☐ Pick up at facility	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD (where available)	N/A
☐ Electronic mail	☐ Secure email ☐ Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address:
☐ Fax	N/A	Fax Number:
☐ Other	Please explain:	

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

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4. **Verbal _____ PLEASE INITIAL HERE** to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.

5. **Requested Health Information:**

☐ Medical Record Abstract (summary of record)

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record

☐ Laboratory results for date of service _____

☐ Radiology images and reports for date of service _____

☐ Itemized bill for _____

☐ Other: Please explain _____

6. **Reason for release of information:**

☐ At request of individual ☐ Other: _____

7. **I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:**

a. I have the right to revoke this Authorization and my Permission to Send Information Requested by Unencrypted E-mail (if indicated in section 3 of this document) at any time by writing to the health care provider listed in Section 1. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.

b. 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.

c. Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

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8. **The following types of information may be released <u>unless</u> you or your authorized representative initial in the appropriate spaces provided below to opt out of releasing these types of health information:**

_____ Substance Abuse Treatment Information from an OASAS licensed unit or program[1] only (including diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)

_____ Mental Health Treatment information from an OMH licensed unit or program[2] only

_____ HIV-Related Information

9. **<u>Expiration Date or Event</u>**

This authorization will expire on (please check one and complete as applicable):
☐ One (1) year
☐ Other (please specify expiration date) _____
*This field must be completed with date or event

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # **OR**	Date	Time		
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

[1] Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.
[2] Units or programs licensed by OMH only include programs whose specific purpose is the treatment of mental Illness.

Please complete this form then email the completed forms with the requested documentation to concordemedicalrecords@northwell.edu or fax them to (212) 253-9631.

If you are unable to complete documents electronically, or are unable to print and complete, please call your provider's office and a copy will be mailed to you.

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