AUTHORIZATION FOR RELEASE OF INFORMATION

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. DO NOT SIGN A BLANK FORM.

SPECIFIC UNDERSTANDINGS

- By signing this authorization form, you authorize the use or disclosure of your protected health information. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.
- If you are authorizing the release of HIV-related information, psychiatric, and/or alcohol or drug treatment information you should be aware that the recipient(s) is prohibited from redisclosing any of this specific information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use this specific information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.
- In addition to the Health and Insurance Portability and Accountability Act (HIPAA) OF 1996, the release of mental health information will be in accordance with the New York Mental Hygiene Law Section 33.13 and 33.16, and the release of alcohol and substance abuse information will be in accordance with 42 C.F.R. part 2, 45 C.F.R. Parts 160 and 164, and New York Confidentiality Laws.

YOUR RIGHTS ARE:

- You can refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.
- You can request to see and copy the information described on this authorization form in accordance with hospital policies.
- If you sign this authorization, you have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to: Privacy Officer / The New York Eye and Ear Infirmary, 310 East 14 Street, New York, New York 10003.
Patient Name: ____________________________  Med. Record # ____________

Address: ____________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

City                                                     State                               Zip

Telephone # ___________________    SS#: ________________________

Date of Birth: _________________

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I hereby authorize the Medical Record Department of The New York Eye and Ear Infirmary to disclose copies of my health information to:

Name: _________________________________________________________________________

Address: _______________________________________________________________________

_______________________________________________________________________

Phone #: __________________________________           FAX #: __________________________

Please release the specific information described below (complete one):

RECORDS CONCERNING TREATMENT FOR THE FOLLOWING MEDICAL CONDITION: _________________   DATE: _________________

INCLUDE ONLY RECORDS FROM ____________ TO ____________ ABSTRACT ___________

LAB __________________________________________________________ DATE ______________

X-RAY _________________________________________________________ DATE  _____________

OTHER ________________________________________________________ DATE ______________

The purpose for which the information will be used or disclosed

IF THE REQUESTED RECORD CONTAINS INFORMATION PERTAINING TO PSYCHIATRIC, DRUG OR ALCOHOL TREATMENT OR CONTAINS HIV RELATED INFORMATION, YOU MUST SPECIFICALLY CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING ONE OR BOTH OF THE FOLLOWING:

____ I understand that if my records contain information pertaining to psychiatric, drug or alcohol treatment, such information will be released pursuant to this consent form

____ I understand that if my records contain confidential HIV information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV

This authorization is valid for 1 year from the date of the patient’s or patient representative’s signature unless otherwise specified: __________________________________________

The date or event that will trigger the expiration

The hospital will be compensated for the cost of copying, mailing or other supplies we use to fulfill your request in accordance with NYS law.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_______________  ______________________
Signature of Patient or Personal Representative  Date

_______________  ______________________
Print Name of Patient or Personal Representative  Description of Personal Representative’s Authority

I.D. Provided: ____________________   Accepted by: ___________     Copy Provided:       Yes      No