AdvantageCare PHYSICIANS

HIPAA Representative Form

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPAA Representative named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below:

Patient Information – Please Print

Patient Name: ______________________________________ Date of Birth: __________________

Address: ______________________________________ City/State/Zip Code:_____________________

Telephone # most easily reached: ______________________________________

HIPAA Representative Information - Please Print

Name: ____ Date of Birth: _______________________

Address: _____________________________________ City/State/Zip Code: ________________________

Telephone # most easily reached: ____________________________

Relationship to Patient:______________________________________

I grant to the HIPAA Representative named above access to:

___All of my PHI – note separate box below is also required for HIV, psychiatric and substance abuse access.

___Other - Specify limits or specific health care incident: ______________________________________

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

I understand that the information in my medical record may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to: (you must initial each area you wish the HIPAA Representative to have access to)

___ Alcohol, drug, or substance abuse information

___ AIDS, HIV-related information (including AIDS related testing and results)

___ Mental Health
___ Sexually Transmitted Disease information
___ Genetic information
___ Research Information

The confidentiality of this record is required under New York State and Federal Law. This material shall not be transmitted to anyone without written consent or authorization.

Signature of Patient for this box:________________________________ Date: _______________

1. I understand that I may revoke this HIPAA Representative designation at any time by notifying the Director of Health Information Management at the following address: 55 Water Street, 12th Floor, Rm 12G09, New York, NY 10041 in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by AdvantageCare Physicians prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will: (Must check one)

( ) expire 1 year from the date executed: or

( ) be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient: ____ Date: _____________

Signature of HIPAA Representative: ____________________________________Date: _____________

(Form will not be valid unless all appropriate blanks are filled)

YOU MAY REFUSE TO SIGN THIS FORM

v.8.23.2018