AdvantageCare BRONX

HIM Department, 55 Water Street, New York, NY 10041

Patient Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth:_____

Address: _____

City/State/ZipCode:_____

Telephone # most easily reached: _____

I request that my protected health information (PHI) **from** AdvantageCare Bronx be disclosed **to**:

☐Self ☐ Name of Facility/Entity: _____Attn:_____

Address: _____

City/State/Zip Code: _____

I authorize the following PHI to be released from my medical record:

- ☐ Abstract/Summary (includes history, office notes, test results, consults)
- ☐ Test results only
- ☐ Other: _____

Covering the following dates of service: _____

I understand that the information in my medical record may include information relating to sensitive information. ***State and federal laws protect this sensitive information. If the information applies to you, please check the information you would like to be released and initial. Provide date(s) if appropriate.***

- ☐ _____Alcohol, drug, or substance abuse records: Date(s): _____
- ☐ _____AIDS, HIV testing/results: Date(s): _____
- ☐ _____Mental health records: Date(s): _____
- ☐ _____Sexually Transmitted Disease records: Date(s): _____
- ☐ _____Genetic records: Date(s): _____
- ☐ _____ Research records: Date(s): _____

Sensitive information of a <u>minor</u> is protected under state and federal regulations. These requests must be forwarded to the HIM department for release.

Purpose for requesting this information:

- ☐ Legal
- ☐ Personal
- ☐ Insurance
- ☐ Continuation of Care
- ☐ Other: (please specify below)

_____

AdvantageCare BRONX

Patient Authorization for Use or Disclosure of Protected Health Information

By signing this authorization form to disclose my medical records, I understand that:

- Requests for copies of medical records may be subject to reproduction fees of $6.50.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the applicable AdvantageCare Bronx office or mailed to the Director of Health Information Management at the following address: 55 Water, New York, NY 10041. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- The Recipient(s) of AIDS/HIV testing/results, alcohol or drug treatment records, or mental health records are prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have a right to request an accounting of disclosures of people who may receive or use my AID/HIV testing/results without authorization. If I experience discrimination because of the release or disclose of AID/HIV testing/results, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- I understand that signing this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

_____ _____

Signature Patient or Authorized Representative Date

_____

Print Name of Patient or Authorized Representative

_____

Relationship to Patient or Authority of Authorized Representative