AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Name of Patient: ____ Patient SSN: _______________________

Patient Date of Birth: ____________________ Patient Telephone Number: __________________________

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. I understand that:

1. This authorization may include disclosure of information related to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATIVE INFORMATION, only if I place my initials in the appropriate line below. If health information includes any of these types of information, and I initial the corresponding areas, I specifically authorize release of such information. If I am authorizing release of such information, the recipient is prohibited from redisclosing 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 NY State Division of Human Rights at (212) 480-2493 or the NYC Commission of Human Rights at (212) 306-7450.
2. I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to health care provider listed below. I understand that uses and disclosures already made based upon my original permission cannot be taken back.
3. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
4. 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.

Name and address of provider or entity to release this information:
__ New York Eye and Face Oculoplastic Surgery PLLC, 244 Westchester Ave, Suite 111, West Harrison, NY 10604 __
Other: ____

Name and address of provider or entity to whom this information will be sent:
__ New York Eye and Face Oculoplastic Surgery PLLC, 244 Westchester Ave, Suite 111, West Harrison, NY 10604 __
Other: ____

Health information to be released
__ My health information covering the period of healthcare from (date) ________________ to (date)__________________ __ exam notes and visual fields __ operative reports __ laboratory results __ imaging studies (ultrasounds, CT, MRI) __ other: ____

Unless you initial here, no information about alcoholism, drug abuse, mental health treatment, sexually transmitted diseases or HIV/AIDS will be disclosed.

______ **Alcohol/Drug treatment** ______ **Mental Health Information** ______ **HIV-Related Information**

The purpose of this authorization is (check all that apply):
__ At my request
__ Other: ________________________________

This authorization ends:
__ On (date)__________ or 1 year from date of my signature __ When the following event occurs:
____

All items on this form have been completed, my questions about the form have been answered, and I have been provided a copy of this form.

Signature of Patient or Authorized Representative:________________________________ **Date**: _______________

Name of Authorized Representative (if not patient): ____
Authority to sign on behalf of the patient: __ Parent __ Legal Guardian __ Court Order __ Other: _____________