SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER

33 West 42nd Street, Room 1024
New York, NY 10036

Tel: 212-938-5840
Fax: 212-938-4177

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:	Date of Birth:	MRN:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of **CONFIDENTIAL HIV* RELATED INFORMATION** only if I check the appropriate box in Item 8(a). The event the health information described below includes **CONFIDENTIAL HIV* RELATED INFORMATION**, and I check the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related 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 New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
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.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **NAME** of health provider or entity to release this information: _____

ADDRESS: _____

_____**PHONE:** _____ **Fax:** _____

7. **NAME** of person or entity to whom this information will be sent: _____

ADDRESS:_____

PHONE: _____ **SEND:** ☐ by fax ☐ by mail **Fax:** _____

8. (a) **SPECIFIC INFORMATION TO BE RELEASED:**

☐ Most Recent Exam ☐ Entire Medical Record ☐ HIV-Related Information* ☐ Other _____

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

OR ☐ Telephone Conversation with _____

9. Reason for release of information:
☐ At request of individual
☐ Other: _____

10. This authorization will expire in one year unless specified:
Date: _____

11. If not the patient, name of person signing form: _____

Relationship to patient: _____

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

_____ **Date:** _____

Signature of patient or representative authorized by law

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.