The Door - Health Services

HIPAA RELEASE OF INFORMATION FORM

Phone Number: (212) 453-0222 | Fax Number: (212) 941-9614

Patient Label

Section 1: Patient Information

Last name:	First Name:		Today's date: / /
Address:		Apartment #:	Date of Birth: / /
City:	State:	Zip Code:	Phone number: ( )

Section 2: Release Information To

I hereby authorize ***The Door - Health Services, 555 Broome St. New York, NY 10013***, to:

☐ **RELEASE INFORMATION TO** **or** ☐ **OBTAIN INFORMATION FROM**

(Place and X in the box that indicates if the information is being released or requested)

Name:	Medical Facility or Organization (include Department):		
Address:			Phone number: ( )
City:	State:	Zip Code:	Fax number: ( )

Section 3: Reason for Release of Information

Reason: I authorize release of information for the following reason:

Section 4: Information to be Released

Release my medical records for the following dates: FROM ___________________________ TO___________________________.

Check **YES or NO** for each of the following types of records:

YES	NO		YES	NO	
☐	☐	Laboratory Results	☐	☐	Vaccination Information
☐	☐	Treatment Medication	☐	☐	Birth Control Information
☐	☐	Other: ____			

Section 5: Sensitive Information

The following categories of information will **NOT** be released from your records without your specific authorization. To authorize release of this information, **sign your complete name** next to the categories of information you want released.

	Patient Signature	Information to be released and Date Range
HIV Related Information		
Mental Health Treatment		
Substance Use & Treatment		

Section 6: Authorization

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

- This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my signature on the appropriate line section 5 of this form. In the event the health information described above includes any of these types of information, and I signed the line in the Sensitive Information section, I specifically authorize release of such information to the person(s) indicated in section 2.
- With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at (888) 392-3644. This agency is responsible for protecting my rights.
- I have the right to revoke this authorization at any time by writing to The Door. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Patient Signature: ____ **Date:** ___________________________

This authorization expires 12 months from the date it was signed unless otherwise specified in Section 5.

Staff Use only	*Staff who Received and Reviewed Form*	*Staff who Processed, and Scanned Form*
Date:		
Signature:		