AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form: In accordance with applicable 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 information relating to **ALCOHOL** and **DRUG ABUSE; MENTAL HEALTH TREATMENT,** except psychotherapy notes; **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION;** and **STD-RELATED INFORMATION (WA)** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV/AIDS-related; STD-related (WA); alcohol or drug treatment; or mental health treatment 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 in NY and NJ I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact federal and state agencies responsible for protecting my rights.
3. I have the right to revoke this authorization at any time, in 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. **This authorization does not authorize you to discuss my health information or medical care with anyone other than the consulting providers, my primary care doctor, or other individual specified in Item 9(b).**

7. Name and address of health provider or entity to release this information**: City Practice Group of NY, LLC ("CityMD") on behalf of the medical practices for which it is the records custodian, 1345 RXR Plaza, Uniondale, NY 11556**

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Check the Practice that applies: ____CityMD ____First Med ____Premier Care ____STAT Health ____Franklin (FIMC) ____Summit Medical Group ____Other: _____

Specific Information to be released:

☐ Medical Record from (insert date)_____to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

☐ Include (indicate by initialing):_____Alcohol/Drug Treatment _____Mental Health Information _____HIV/AIDS-related Information _____STD-related Information (WA)

9(b). Authorization to Discuss Health Information:

By initialing here_____I authorize CityMD to discuss my health care with consulting providers, my primary care doctor, and_____.
(Name of Individual)

10. Reason for release of information: ☐ At request of individual ☐ Other:	**11. Date or event on which this authorization will expire:**
12. If not the patient, name of person signing form:	**13. Authority to sign on behalf of 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.

Signature of patient or representative authorized by law:_____Date: _____

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

WA: NOTICE TO RECIPENTS: This information has been disclosed to you from records whose confidentiality is protected by federal and state law. If these records contain information about HIV/AIDS, STDs, or alcohol or drug abuse, you may not further disclose the information with specific written authorization from the person to whom it pertains or as otherwise permitted by federal or state law. A general authorization for the release of medical records or other information is not sufficient for this purpose.