Community Health Center of the North Country

Authorization to Release Records

Patient Name: _____ Date of Birth: _____

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. Information related to **Mental Health Treatment (except psychotherapy notes)**, **Alcohol or Drug Abuse**, and **Confidential HIV Related Information** will not be released unless initialed by the patient or personal representative in box 9(a). If any of the records include any of these types of information and the lines in box 9(a) are initialed, I specifically authorize release of such information to the person(s) listed in box 8.
2. If I have authorized the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-releasing this 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.
3. I have the right to cancel this authorization at any time by writing to the health care provider listed below, except for information that has already been released in regards to this form.
4. I understand that signing this authorization is voluntary and my treatment and payment information will not be affected.
5. Information disclosed under this authorization might be re-released by the recipient except **Mental Health Treatment (except psychotherapy notes)**, **Alcohol or Drug Abuse**, and **Confidential HIV Related Information**, and this re-releasing 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 ATTORNEY, GOVERNMENTAL AGENCY, OR HEALTH CARE PROVIDER SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release the information:

8. Name and address of person(s) where the information will be sent:

9(a). Specific information to be released:

☐Medical Records from (Insert Date):_____ to (Insert Date): _____

☐Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, 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-Related Information

Authorization to Discuss Health Information

(b). By initialing here _____, I authorize _____ to discuss
(Initials) (CHC health care provider)
health information with my attorney, governmental agency, or another health care provider, listed here:

_____
(Attorney, Governmental Agency, Health Care Provider)

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

Created: 1/14/2019 Revised: 3/14/2019