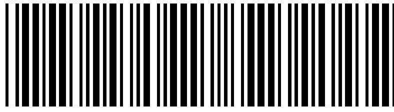

CO2C712

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	**Date of Birth:**	**Telephone Number:**
Patient Address:		

I, or my authorized (approved) representative, authorize (permit) health information regarding my care and treatment to 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 (sending) of information relating to ALCOHOL AND/OR DRUG ABUSE TREATMENT (from units or programs that provide drug/alcohol treatment), MENTAL HEALTH TREATMENT (from units/programs that provide mental health treatment), and CONFIDENTIAL HIV/AIDS RELATED INFORMATION (information that could reasonably identify someone as having HIV symptoms or infection), only if I place my initials on the correct line in Item 8. If the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize the release of such information to the person(s) or entity indicated in Item 7.
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is not allowed to re-disclose such information without my authorization unless allowed under federal or state law. I understand that I have the right to request a list of disclosures of my HIV/AIDS-related information. 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 1-888-392-3644 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are there to help protect my rights.
3. I have the right to revoke (change my mind about) this authorization at any time by writing to the heath care provider listed below. I understand that I may revoke this authorization except for information that has already been disclosed.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be denied by Stony Brook Medicine based on whether or not I sign this form.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.

6. Health Care Provider or Entity to Release this Health Information:

Name:	Address:
Telephone Number:	

7. Person or Entity to Receive this Health Information:

Name:	Address:
Telephone Number:	
E-mail Address:	Fax Number:

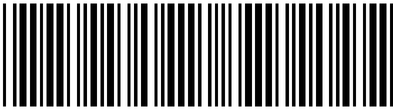
8. Specific Information to be Released:

	Include: (indicate by initialing)
☐ Medical record from (insert date) ________ to (insert date) ________	_______ Alcohol/Drug Treatment Information (may include diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)
☐ Entire medical record	_______ Mental Health Treatment Information
☐ Laboratory results for date of service ________	_______ HIV-Related Information
☐ Radiology images and reports for date of service _______	
☐ Medical record abstract (summary) of information related to the following dates of service: ____________________	
☐ Other: ____________________	

9a. Method of Release of Health Information:

Manner of Release	Form/Format of Requested Information	Delivery Information
☐ Regular mail	☐ Paper copy ☐ CD	Mailing address:

English: CO2C712 (1/24)
Spanish: CO2S712 (1/24)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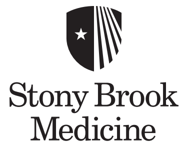

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

☐ Pick up at facility	☐ Paper copy ☐ CD	N/A
☐ Secure electronic mail (E-mail)	N/A	E-mail address:
☐ Fax	N/A	Fax number:
☐ Other: Please explain:		

9b. Authorization to Discuss Health Information

By initialing here _______, I authorize the Health Care Provider or Entity named in Section 6 of this form to discuss my health information as specified in Section 8 of this form with the Person or Entity named in Section 7 of this form.

10. Reason for the Release of Health Information:	**11. Date or Event on which this Authorization will Expire:**
☐ At the request of the individual ☐ Other: ______________________________	
12. If not the patient, name of person signing form:	**13. If not the patient, authority to sign on behalf of patient:**

Print Name: ______________________________

Signature: X______________________________ **Date:** __________ **Time:** __________

English: CO2C712 (1/24)
Spanish: CO2S712 (1/24)