

## Authorization for Release of Health Information Pursuant to HIPAA

PATIENT NAME (PRINT)	DATE OF BIRTH
PATIENT ADDRESS (PRINT AND INCLUDE APT#)	TELEPHONE NUMBER
	EMAIL ADDRESS

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed 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 information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\*-RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(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 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, alcohol, drug treatment, or mental health related 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 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 and address of health care provider or entity to release this information: <p style="text-align: center;"><b>Phelps Hospital Northwell Health</b></p>
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6a. If you are requesting only laboratory results directly from Northwell Health Laboratories, enter "Northwell Health Laboratories" above. Provide the following information and then go directly to Sections 8, 10, 11, 12 and 13 and sign as indicated below item 13.

Ordering Physician's Name: _____
Information to Be Released: <u>Laboratory testing results</u>
Date Of Service: ____/____/____

Authorized Recipient:	<input type="checkbox"/> Patient	<input type="checkbox"/> Patient's Designee (or parent of unemancipated minor patient)	Name of Designee _____ Relationship _____
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<input type="checkbox"/> Consulting Physician:	Name: _____ Telephone: (____) _____ Address: _____
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The laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of laboratory results. All questions regarding testing and the results will be answered by the PATIENT'S PHYSICIAN ONLY. Reports will generally be available 4 days after ALL laboratory test result are complete.

Result option (select one) \_\_\_\_\_  Mail \_\_\_\_\_  Fax \_\_\_\_\_  Pick-Up (at any Patient Service Center)

Patient or Representative Initials:

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7. Name, address, telephone and fax numbers of person(s) or category of person to whom this information will be sent:	
Full Name (Print): _____	Phone #: _____
Full Address (Print and include Apt or Suite #): _____	Fax #: _____
	Email Address: _____
8. (a). Specific information to be released:	
<input type="checkbox"/> Medical Record Abstract <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> Designated Record Set <input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.	
<input type="checkbox"/> Other: _____    Include: (Indicate by initialing)	
_____ <b>Alcohol/Drug Treatment</b>	
_____ <b>Mental Health Related Information</b>	
_____ <b>HIV-Related Information</b>	
8. (b). <b>Authorization to Discuss Health Information</b>	
<input type="checkbox"/> By initialing here _____ I authorize _____	
Initials	Name of individual health care provider
to discuss my health information with the individual listed: _____	
Individual Name	
9. Reason for release of information:	10. Date or event on which this authorization will expire:
<input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	<b>One year from signature.</b>
11. Printed name and signature of person signing form:	12. Authority to sign on behalf of patient or 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.

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient
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Telephonic Interpreter's ID #	Date / Time
OR	

Signature: Interpreter	Date / Time	Print: Interpreter's Name and Relationship to Patient
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Witness to signature (Signature)	Date / Time	Print Witness Name
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\* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

\* **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.**

Internal Use Only - Student Immunization Authorization	
Consent provided by _____	
Consent provided by: _____	Relationship to Patient: _____ Name
of HIM Staff Member who obtained verbal consent: _____	Date Processed: _____ Internal Use
Only - For Northwell Health Laboratories Use Only:	
Date: ____/____/____; Time: ____:____:____; Personnel Name: _____; Accession #: _____	

## Electronic Communication Consent:

If you choose to request your record via e-mail, Northwell Health asks that you acknowledge and consent to the following:

Unless I specifically request otherwise, e-mails sent to me from Northwell Health will be encrypted to keep them secure during transmission. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails and, therefore, e-mails that I send from my email account may not be protected from inappropriate access by others via hacking or other means. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to transmit my personal health information via e-mail.

I further acknowledge that e-mails may be inadvertently sent to the wrong address and subject to technical malfunctions. Therefore, I understand that e-mail delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that I or my healthcare provider can terminate e-mail communication services at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or if my e-mail address has changed.

\_\_\_\_\_  
Patient/Agent/Relative/Guardian\* (Signature)      Date / Time

\_\_\_\_\_  
Print Name      Relationship if other than patient

\_\_\_\_\_  
Telephonic Interpreter's ID #      Date / Time

**OR**

\_\_\_\_\_  
Signature: Interpreter      Date / Time

\_\_\_\_\_  
Print: Interpreter's Name and Relationship to Patient

\_\_\_\_\_  
Witness to signature (Signature)      Date / Time

\_\_\_\_\_  
Print Witness Name

\* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

### **Request for Email Communication via Unencrypted Email Only**

Northwell strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

\_\_\_\_\_  
Patient/Agent/Relative/Guardian\* (Signature)      Date / Time

\_\_\_\_\_  
Print Name      Relationship if other than patient