HPF2.02a Authorization/Request to Use and/or Disclose (Release) Protected Health Information

Patient/Client Name _____ DOB _____

Address _____ Tel. _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. In accordance with federal and state law, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. All fields must be completed. **DO NOT SIGN A BLANK FORM.**

Use and Disclosure Covered by This Authorization

Who will disclose the information?_____

Who will use and/or receive the information?_____

What information will be used or disclosed?_____

Specific Date(s) of Service (if applicable):_____

By initialing next to each applicable category, I authorize the disclosure/release to include the following sensitive protected health information:

☐ Psychotherapy Notes ONLY* (by initialing, I am waiving any psychotherapist-patient privilege)

☐ Behavioral and Mental Health Information** ☐ Substance Abuse Treatment Records

☐ Genetic Testing Information ☐ Other: _____

* As defined by HIPAA, psychotherapy notes are the notes maintained separately from the designated record set.

** I understand that information from mental health clinical records may be released pursuant to this authorization to the person/entity identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient/client or another person.

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 a separate authorization is required for disclosure of protected health information related to AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus) including but not limited to test results and the fact that the test was performed.

What is the purpose of the use or disclosure? ☐ At my request ☐ Continuity of care/treatment

☐ Other: _____

When will this authorization expire? ____/____/_____, _____(If expiration date/event is not specified, this authorization will expire when the above named residence/agency/ program/person, authorized to receive this information, is no longer involved in the patient's/client's care)

I further understand that:

1. By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. Once disclosed, this information may no longer be protected by the federal HIPAA privacy regulations and may be re-disclosed if the recipient(s) described on this form is not required by other laws or regulations to protect the privacy of the information.
2. I will have the right to revoke this authorization at any time, except to the extent that YAI has already taken action based upon my authorization.
3. I will be provided with a copy of this authorization.
4. I have the right to inspect/receive copy of the information to be used or disclosed.
5. This authorization is voluntary and I may refuse to sign it.
6. My treatment, payment, enrollment in health plan or eligibility for benefits will not be conditioned based on this authorization.

Signature

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____ Date: _____/_____/_____
Signature of Patient/Client or Personal Representative

_____
Print Name of Patient/Client or Personal Representative Description of Personal Representative (if applicable)

Witnessed: _____ Date: _____/_____/_____