NewYork-Presbyterian Queens

NYP/Q HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME	MAIDEN OR OTHER NAME		DATE OF BIRTH
ADDRESS	PATIENT EMAIL ADDRESS	MEDICAL RECORD #	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED:
NewYork-Presbyterian/Queens	INFORMATION REQUEST FROM DATES:_____ ABSTRACT _____ TEST RESULTS _____ CLINIC_____
NAME AND ADDRESS OF PERSON OR ENTITY TO WHOM INFO WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request. NYP/Q cannot ensure all references for declined information will be identified.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal- Matter ☐ Individual Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date_____ Or one year after signing

- I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.
- I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by the law to protect the privacy of the information.
- I understand that if my medical and/or billing record contains information relating to **ALCOHOL** or **SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION,** this information will not be released to the person(s) I have indicated unless I check the boxe(s) for this information on this form.
- I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under the federal or state law. I also understand that I have the right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If experience discrimination because of the use or disclosure of HIV/AIDS-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.
- I understand that I have the right to refuse to sign this authorization and that my health care, the payment of my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this form, NYP/Q cannot honor my request to disclose my medical and/or billing information.
- I understand that I have the right to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have the right to receive a copy of this form after I have signed it.
- I understand that if I signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYP/Q has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

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

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE X	IF NOT PATIENT PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
WITNESS OR NOTARY	
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVES AUTHORITY TO ACT ON BEHALF OF PATIENT

Providers are permitted to charge reasonable fees to recover costs for inspection, production, and/or copying for ( ) paper ( ) PDF image ( ) secure file transfer via email as provided.

NYP/Q USE ONLY

Date Received: Initials of HIM employee processing request:
Date Completed: Comments: