FDNY HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

PATIENT NAME	DATE OF BIRTH	PATIENT SSN (LAST 4 DIGITS ONLY)
PATIENT ADDRESS	WTC HP ID # (IF APPLICABLE)	TELEPHONE #

NAME OF/HEALTH PROVIDER(S) AUTHORIZED TO RELEASE INFORMATION NAME AND ADDRESS OF PERSON OR ENTITY TO WHOM INFORMATION WILL BE SENT	**SPECIFIC INFORMATION TO BE RELEASED** (*If the box is checked you are authorizing the release of that type of information. If the box is not checked we may be unable to process your request*): ☐ Medical Information requested: ____ ☐ Treatment dates from: _____________________ to ________________________ ☐ Entire Medical Record, including patient histories, office notes, (except psychotherapy notes), test results, radiology studies, films, and referral consults, billing records (if applicable), insurance records (if applicable), and records sent to you by other health care providers. **Include:** ☐ Alcohol and/or Substance Abuse Information ☐ Genetic ☐ HIV/AIDS information ☐ Mental Health Information ☐ Other (please specify): ____

Authorization to Discuss Health Information

By initialing here ___________ I authorize ____to discuss my health information with my attorney,
(*Your Initials*) (*Name of individual healthcare provider*)

or a government agency listed here: ____.
(*Attorney/Firm Name or Governmental Agency Name*)

REASON FOR RELEASE OF INFORMATION: ☐ Legal Matter ☐ At request of Individual ☐ Other (please specify):_____________________________	WHEN WILL THIS AUTHORIZATON EXPIRE? (Please check one) ☐ Event:_____________________ ☐ On this date: _________________________

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described 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 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 law to protect the privacy of the information.

I understand that if my medical and/or billing records contain 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 box(es) 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 federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I 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 a right to refuse to sign this authorization and that my health care, the payment for 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 authorization, FDNY cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a FDNY Authorization Form for Release of Protected Health Information Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have 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 FDNY 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 FDNY HIPAA Privacy Officer or the Bureau processing this request.

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

If not the patient, name of person signing form:	Authority to sign on behalf of patient:
Signature:	Date: