Human Resources Administration
Department of Social Services

HIPAA AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

Patient Name:		**Social Security Number:**	
Patient Address:		**Date of Birth:**	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with Article 27-F of the New York State Public Health Law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, 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 10(b). 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 10(b), I specifically authorize release of such information indicated in Item 10(b) to the NYC Human Resources Administration (HRA).
2. In the event that HRA determines that I am potentially eligible for federal disability benefits, I authorize HRA to release my medical and/or mental health treatment information, which may include confidential HIV related information and/or alcohol or drug treatment records to the Social Security Administration (SSA) for its review of my eligibility for federal disability benefits.
3. 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) 961-8650** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.
4. I understand that signing this authorization is voluntary. My treatment, payment to treatment providers, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize HRA to share my medical information with SSA, this may result in a discontinuance of my Cash Assistance (CA) benefits.
5. I understand that I may revoke this authorization except to the extent that HRA and my medical provider have already acted upon it. I may revoke this authorization at any time by writing to the health care provider at the address specified below and to HRA at: **NYC Human Resources Administration, Office of Constituent Services, 150 Greenwich Street, 31st Floor, New York, NY 10007**
6. Authorized recipients of my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.
7. **This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than the NYC Human Resources Administration as specified in item 10(b)**.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

8. Name and address of health provider or entity to release this information: _____

_____

9. Name and address of agency to whom this information will be sent: **NYC Human Resources Administration, Customized Assistance Services, Office of Reasonable Accommodations, 150 Greenwich Street, 30th floor, New York, NY 10007**

10(a). Specific information to be released: **Medical records for the entire year prior to the signature date below.**
Include (*Indicate by Initialing*):

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV Related Information

10(b). By initialing here _____, I authorize _____
(Initials) (Name of individual health care provider)
to discuss my health information with the **NYC Human Resources Administration**.

11. Reason for release of information: **At request of patient**
12. Date or event on which this authorization will expire: **One year from the date of signature**
13. If not the patient, name of person signing form: _____
14. Authority to sign on behalf of patient: _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided with a copy of the form.

_____ _____
Signature of Patient or Authorized Representative by Law Date

***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.**