HELEN HAYES
HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

HHROI

Authorization to Release Personal Health Information

I hereby authorize Helen Hayes Hospital to disclose and release all of the health information possessed or maintained by the Hospital, as indicated below:

Patient's/Resident's full name _____ Date of birth _____

Information to be released: ❑ Entire Record ❑ Abstract Only ❑ Discharge Summary ❑ Outpatient ❑ Radiology
❑ Other _____ Date Range: _____

Include (indicate by initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

Name of recipient _____ Address _____ City, State _____ Zip _____
Email _____ Fax Number _____

Name of recipient _____ Address _____ City, State _____ Zip _____
Email _____ Fax Number _____

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 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 relation to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my intitials on the appropriate line item above. In the event the health information described above includes any of these types of information, and I initital the line above, I specifically authorize release of such information the person(s) indicate above.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health 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 infromation without authorization. If I experience discrimination because of the state 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 Helen Hayes Hospital. 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. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED ABOVE.

Signature of Patient or Representative Authorized by Law _____ Date _____

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably identify someone as having symptoms or infection and information regarding a person's contacts.**