NYOH New York Oncology Hematology

Authorization for Release of Health Information

Patient Name:	Date of Birth:	Patient Account:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, CONFIDENTIAL HIV/AIDS RELATED INFORMATION and GENETIC TESTING only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, genetic testing, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information to:

6. Name and Address of Person(s) to Whom this Information Can be Disclosed to:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (Insert Start Date) until _____ (Insert Expiration Date or Event)

☐ All health information (written and oral), except

_____

For the following information to be disclosed to the party set forth above, please indicate the information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs		
☐ HIV/AIDS related information		
☐ Genetic testing records		

9. If not patient, name of person signing form:	10. Authority to sign on behalf of patient:

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

X _____ _____
Signature of Patient or Representative Authorized by Law — Date

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
Witness Name — Witness Signature — Date