Authorization Form for Use or Disclosure of Protected Health Information

I authorize New York Spine and Wellness Center to disclose my protected health information ("PHI") to the individual or entity named below. This authorization form is voluntary; New York Spine and Wellness Center will not condition my treatment on the signing of this authorization form.

Please Complete the Following Information

1. Individual Information:
   Name: ____
   Address: ____
   City: ______________________ State: __________ Zip: ______________
   Date of Birth: ______________________

2. Individual or Entity Authorized to Receive PHI: Please provide the name and address of the Individual or Entity to whom you are authorizing New York Spine and Wellness Center to disclose your PHI:

   Name: ____
   Address: ____
   City: ____________ State: _____ Zip: ______Fax#________________

3. Description of PHI to be Disclosed: Please indicate the *specific PHI* to be disclosed (e.g., lab results; x-ray reports; specific dates of service; entire medical record; etc.):
   ____
   ____
   ____

4. Reason for Disclosure: List specific reason for disclosure of the above stated PHI **("At the request of the individual**" is acceptable if the request is made by the patient and the patient does not want to state a specific purpose)
   ____
   ____

5. Expiration Date: This authorization shall become effective immediately, and unless otherwise revoked, shall expire on:
   - □ Upon completion of requested disclosure
   - □ On ________/______/____________ (indicate specific date)
   - □ Other ____

   (Indicate date or event on which the authorization shall expire)

Right to revoke authorization: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at.5496 East Taft Rd, North Syracuse, NY 13212. I understand that a revocation is not effective to the extent that New York Spine and Wellness Center has already relied upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA privacy regulations.

Dated: ____________________

____	____
Signature of Individual	Printed Name of Individual

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

____	____
Signature of Personal Representative	Printed Name of Personal Representative

Description of authority: ____
(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, power of attorney)

Please Note: If your protected health information contains HIV-related information the New York State Department of Health requires the attached Authorization for Release of Confidential HIV-related Information be completed.

New York State Department of Health

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ Both (non-HIV medical and HIV-related information)
- ☐ My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

____

____

Name of person whose information will be released: ______________________________

Name and address of person signing this form (if other than above):

____

____

Relationship to person whose information will be released:______________________

____

Describe information to be released:______________________________

Reason for release of information: ______________________________

Time Period During Which Release of Information is Authorized From: ____________ To: ____________

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:

____

____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligiblity for benefits (Note: Federal privacy regulations may restrict some consequences):

____

____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature ______________________________ Date ____________

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Please Complete Information on Page 2.

Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature ______________________________________ Date ______________
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: ______________________

Print Name ______________________________________

Client/Patient Number ______________________________________

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

____

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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If any/all of this page is completed, please sign below:

Signature ____ Date ____________________

Client/Patient Number ____