MRN

WINTHROP
University Hospital
Your Health Means Everything

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

*This form is to be used in conjunction with the **NEW YORK STATE DEPARTMENT OF HEALTH-AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (INCLUDING ALCOHOL/DRUG TREATMENT AND MENTAL HEALTH INFORMATION) AND CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**

1. I hereby authorize (name of provider) _____

2. To disclose the following information from the health records of:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

3. Information to be disclosed: Date(s) of Service: _____

☐ Complete health records ☐ Discharge Summary ☐ X-Ray Reports ☐ Consultation Reports

☐ History & Physical Exam ☐ Progress Notes ☐Laboratory test ☐ Other (see below)

Other (please specify): _____

4. Medical Records will be released on paper only Initials _____

5. Method of distribution for Continuity of Care Document (CCD) or Discharge Instructions * (must check one):

☐ Paper ☐ CD ☐ USB Flash Drive

* Electronic Discharge Instructions or Continuity of Care Document must be requested in person in the HIM Department on the 3rd floor if requested at the time of discharge or hospitalization.

Patient Signature	Date	Time
Legal Representative Signature	Relationship to Patient/ Description of Authority	Date
Witness Signature	Relationship to Patient	Date

Note: Release of all confidential information is governed by State, Federal and HIPAA Regulations.

HIM Use Only

Date Rec'd _____
Time Rec'd _____

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
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, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION 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, 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:

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

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 to be included, indicate the specific 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		

9. If not the 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.

_____ _____
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.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.