## Olean Medical Group LLP

535 Main Street Olean, New York 14760 (716) 372-0141 Fax (716) 372-6421

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name	Date of Birth	MR#

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 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 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) located in Item 7.
- 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 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) 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 the health care provider listed below. 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.	Name and address of health provider or entity to release this infe	ormation:	
7.	Name and address of person(s) or category of person to whom t	his information will be sent:	
8.	Specific information to be released:  Medical Record from (insert date)  Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records sent to Other:	to (insert date) otes (except psychotherapy notes), test results, radiology studies, films, o you by other health care providers.  INCLUDE:Alcohol/Drug Treatment (Indicate byMental Health Information Initializing)HIV-Related Information	
9.	Reason for release of information:  At request of individual Other:		
10.	If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:	
All itei	ns on this form have been completed and my question	ns about this form have been answered.	
 Signati	are of patient or representative authorized by law	Date	