

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name	Date of Birth	Patient Identification Number/OSIS#
Patient Address		

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 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/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. 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 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH 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 the people who may receive or use my HIV/AIDS-related information without authorization. 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 (888) 392-3644 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 providers I have authorized to release my information. 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 may be redisclosed by DOHMH or DOE (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.**

7. Specific information to be released and discussed:
All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers.

For patients with any of the health conditions listed below, initial to authorize release of information: (Indicate by initialing)

_____ Behavioral Health/Mental Health Information

_____ Alcohol/Drug Treatment Information. Specify records to be released and releasing organization: _____

_____ HIV/AIDS-Related Information

If this box is checked, release and discuss only health information specified here: _____
(Use this box if you do not want the entire record released or disclosed)

8. REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT THE REQUEST OF THE PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW, UNLESS OTHERWISE SPECIFIED HERE:	9. THIS AUTHORIZATION WILL LAST UNTIL THE PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS AN EXPIRATION DATE IS LISTED HERE:
10. IF NOT THE PATIENT, PRINT NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)	11. RELATIONSHIP TO PATIENT: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other (please describe below)

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

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

**If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law.