HarmonyHealthcare Long Island

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: Sally Smith	Date of Birth: 08/08/1988
	Social Security Number:
Address: 100 Harmony Street Westbury, NY 11514	

I, or my authorized representative, request that health information regarding my care and treatment 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 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S) SPECIFIED IN ITEM 9 (b).**

7. Contact information or health care provider or entity to release this information (from who):

Name: Harmony Healthcare Long Island at Roosevelt	Address: 380 Nassau Road Roosevelt, New York 11575
Phone: (516) 571-8600	

8. Contact information of person(s) or entities who will receive this information (to who):

Name: Sally Smith		Address: 100 Harmony Street Westbury, NY 11514
Phone: 888-888-8888	Fax: 888-888-8889	E-mail: sallysmith@HHLI.org

Delivery Details: (**check one**)

☐ Regular mail
☑ Fax (include fax number above)
☐ E-mail (include email above)
☐ Pick up at HHLI Roosevelt
380 Nassau Road Roosevelt NY 11575
☐ Other (please explain): _____

9 (a). Specific information to be released:

☑ Medical Record from (insert date) 01/01/2022 to (insert date) 01/01/2023
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers.
☐ Other: _____

Include: (*Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

HarmonyHealthcare
Long Island

Authorization to discuss health information

9 (b). ☐ By initialing here _____ I authorize _____

(Name of individual health care provider)

to discuss my health information with _____

_____

Relationship to patient: _____

10. Reason for release of information: ☐ At request of individual ☐ Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

Sally Smith

Signature of Patient or representative authorized by law.

08/08/2023

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.**