Individual Authorization for Release of Information

OFFICE USE ONLY

MRN: _____

Patient Name: _____

Patient Name: **Date of Birth:** _____

Address: _____

Telephone: _____ **Email (optional):** _____

Please mail the completed form to: Health Information Management Department
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Or fax the form to: (212) 774-7364 or (212) 606-1859

We understand that health information is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain written authorization before we may use or disclose protected health information for the purposes described below. This form provides that authorization and helps us make sure you are properly informed of how this information will be used or disclosed. Please carefully read the information below before signing this form. *DO NOT SIGN A BLANK FORM.*

Who will disclose the information? HSS is authorized to disclose the information described below.

Who will use and/or receive the information? The person(s), or class of persons, authorized to use and/or receive the information: _____

_____

_____

What information will be used or disclosed? I authorize HSS to use or disclose the following information (check where applicable):

☐ **Entire Record** (Note: Does not include Billing Statements)	☐ Face Sheet – Date(s) of Service:	
☐ Billing Statements	☐ EKG Reports	☐ Operative Reports
☐ Consultations	☐ History & Physical Exams	☐ Pathology Reports
☐ Discharge Summary	☐ HIV/AIDS Test Results	☐ Progress Notes
☐ Radiology and/or MRI Reports	☐ Laboratory Reports	☐ Rehabilitation Records
☐ Radiology and/or MRI Images	☐ Outpatient Clinic Reports	☐ Implant Records
☐ HSS Physician Office Records – Physician's Name:		
☐ Other:		

Include the following information (indicate by initialing below – **please note that the information will not be released if *not* initialed**):

_____ Substance Use Disorder	_____ Psychiatric/Psychotherapy Care	_____ Sexually Transmitted Disease
_____ Tuberculosis	_____ Genetic Testing	_____ HIV-Related[1]

Include the above information for the following date(s) of service: _____/_____/_____ to _____/_____/_____

What is the purpose of the use or disclosure? (check where applicable)

☐ Patient's Request	☐ Medical Care	☐ Insurance
☐ Immunization	☐ Legal	☐ Other:
☐ Support for an application, claim or appeal for a government benefit or government program		

When will this authorization expire? The date or event that will trigger the expiration of this authorization is: _____

_____

1 Any information indicating you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information that could indicate you potentially have been exposed to HIV.

If you have questions, please call the HSS Health Information Management Department at (646) 797-8254 during regular business hours (8am – 5pm, Monday – Friday)

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SPECIFIC UNDERSTANDINGS

By signing this authorization, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

If you are authorizing the release of HIV-related information, you should be aware that any recipient is prohibited from redisclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your health care, the payment for your healthcare, and your health care benefits will not be affected if you do not sign this form, but we will not be permitted to use or disclose your information as described on this form without your signature.

You have a right to receive a copy of this form after you sign it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that HSS has already taken action based upon your prior authorization. To revoke this authorization, please write to the HSS Health Information Management Department at 535 East 70th Street, New York, NY, 10021.

We may charge a reasonable fee for the cost of copying, mailing, or supplies used to fulfill your request. The fee must generally be paid before, or at the time, we release the information. You will receive an invoice detailing the fee; you will have an opportunity to modify or withdraw your request if you do not want to pay the fee. Please note, patients will not be charged a fee for release of protected health information that is disclosed directly to their physicians or caregivers (for continued medical care or treatment).

SIGNATURE

I have read this authorization and my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above and understand that the requested information will be disclosed to me as permitted by law.

_____

Signature of Patient or Personal Representative

Note: A Personal Representative is an individual authorized, by law, to act on behalf of the patient. Examples include parents or guardians of unemancipated minors, health care agents, and powers of attorney.

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date

If you are requesting records on behalf of an adolescent patient (ages 12-18), the adolescent patient must sign below. (NYS Public Health Law §§ 17 and 18)

_____

Signature of Adolescent Patient

THE PATIENT, OR THEIR PERSONAL REPRESENTATIVE, MUST BE PROVIDED A COPY OF THIS AUTHORIZATION AFTER IT HAS BEEN SIGNED.

If you have questions, please call the HSS Health Information Management Department at (646) 797-8254 during regular business hours (8am – 5pm, Monday – Friday)

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV*-RELATED INFORMATION

Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has potentially been 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 New York 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 health 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 more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By initialing "HIV-Related" information on page 1 of this authorization, HIV-related information can be given to the people listed on the form, for the reason(s) listed. Upon your request, HSS or person asking for this authorization must provide you with a copy of this authorization.

*Human Immunodeficiency Virus that causes AIDS.

RELEASE OF CONFIDENTAIL SUBSTANCE USE DISORDER INFORMATION

If the use or disclosure you requested includes confidential substance use disorder information, the following notice will be included with the release:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having, or having had, a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person, unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed, or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.