ConnextCare™ A Community of Care

61 Delano Street, Pulaski, New York 13142-1400
Phone: (315) 298-6569 Fax: (315) 298-7488 TDD: 711
www.connextcare.org

Mexico Location
5856 Scenic Avenue
Mexico, New York 13114
Phone: 315- 963-4133 Fax: 315- 963-4960

THIS SECTION IS FOR OFFICE USE ONLY
Date Received _____
Date Completed _____
By_____

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name (Include any Maiden names &/or Alias)	Date of Birth	Medical Record Number
Patient Address	SS#	Phone Number

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 9. 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, I specifically authorize release of such information to the person(s) indicated in Item 7.
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, Substance Use Disorder treatment (SUD), 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/SUD/MH 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 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signed this form.
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. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in Item 2), and this re-disclosure may no longer be protected by federal or state law. I understand that in compliance with New York State statute, I shall pay a fee of $.75 per page or $3.00 (whichever is less). There is no charge for referral care of follow up treatment.

6. Name, Phone Number, Fax Number, and Address of Provider or Entity to Release this Information:

7. Name, Phone Number, Fax Number, and Address of Person(s) to Whom this Information Will Be Disclosed:

8. Reason for Release of Information:
☐ Changing Primary Care Physician ☐ Specialist/Referral/Continuity of Care ☐ Legal or Insurance purposes ☐ Other:_____

9. 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: _____
☐ Only the following specific information: _____

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		

10. If not the patient, name of person signing form:	11. 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

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.

_____ _____ _____
WITNESS SIGNATURE DATE

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.