Pulaski Dental
61 Delano Street
Pulaski, New York 13142
Phone: 315-298-6815 Fax: 315-298-1933

AUTHORIZATION FOR RELEASE/REQUEST OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	**Maiden/Other Name:**	**Date of Birth:**	**SS #**
Patient Address:		**Phone Number:**	

I, or my authorized representative, request that the health information regarding my care and treatment be released as set forth on this form; In accordance with Federal Regulations, New York State Law and the Privacy Rule of the Health Insurance Portability Accountability Act of 1996 (HIPAA) I understand that:

1. This authorization may include disclosure of information relating to **SUBSTANCE USE DISORDER, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV-RELATED* INFORMATION** unless I place my initials on the appropriate line in item (8a). In the event the health information described below includes any of these types of information, and I do not initial the line on the box in item 8(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, substance use disorder, or mental health treatment information, the recipient is prohibited from re-disclosing 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 1-888-392-3644 TDD/TTY 718-741-8300.This agency is responsible for protecting my rights.
3. My records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
4. 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. I understand that this authorization will expire **90 days** or upon completion after I have signed this form.
5. 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.
6. 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 statue, 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.

7. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED BELOW.**

8. I hereby authorize ConnextCare to: ☐ **RELEASE {TO}** ☐ **REQUEST {FROM} my dental record as indicated below**

Medical Provider/Facility/Patient_____Phone # _____ Fax#_____

Address:_____City_____State_____Zip_____

Specific Information to be disclosed: ☐ Entire dental record ☐ Most recent 2 years of records ☐ Dental X-rays only

OR ☐ Information from (insert date) _____ to (insert date)_____

☐ Other _____

Authorization to Discuss Health information

☐ By initialing here _____I authorize _____ to discuss my health information with my attorney or governmental agency, listed here: _____

Reason for release of information ☐ Transfer of Care ☐ Insurance Reimbursement ☐ At Request of Patient

I have the authority to sign this form on behalf of patient ☐ Yes ☐ No Relationship to Patient _____

_____ _____

Signature of Patient/Parent/Legal Representative **Date**

Office use only: Date Received _____ Date Completed _____ By_____