

**Medina Memorial Health Care System**  
 200 Ohio St  
 Medina, NY 14103

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		Phone:

I, or my authorized representative, request that health information regarding my care and treatment be released by **Medina Memorial Healthcare System** as specified 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 in relation to **Drug and Alcohol Treatment, Behavioral Health/Psychiatric Records** and **HIV Related Information** if I place my initials on the appropriate line in item 6. In the event the health information described below includes any of these types of information, and I initial the line in the box in Item 6, then I specifically authorize release of such information to the person(s) indicated in Item 5. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 & 164. I understand that if I authorize the release of behavioral health information, the disclosing party named below will disclose such information in accordance with Section 33.13 and 33.16 of the Mental Hygiene Law. Redisclosure of this information to another party is forbidden without additional written authorization on my part.

2. If I am authorizing the release of HIV-related information, drug or alcohol treatment, 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.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

5. Name and address of entity/person(s) to whom this information will be sent:	
6. Specific information to be released:	
<input type="checkbox"/> Treatment Dates: from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> Entire Medical Record. (If this is initialed, patient must also separately initial the categories below if Behavioral Health records, Drug and Alcohol Treatment records and/or HIV-related records are to be used or disclosed).	
<input type="checkbox"/> Radiology Reports: _____ <input type="checkbox"/> Emergency Room Record: _____ <input type="checkbox"/> Lab Reports: _____ <input type="checkbox"/> Billing records: _____ <input type="checkbox"/> Other: _____	Include: (indicate by initialing)  <input type="checkbox"/> <b>Drug/Alcohol Treatment Records</b> <input type="checkbox"/> <b>Behaviorial Health/Psychiatric Records</b> <input type="checkbox"/> <b>HIV-Related Records</b>
7. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	8. Date on which this authorization will expire:
9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered.

\_\_\_\_\_  
 Signature of patient or representative authorized by law

\_\_\_\_\_  
 Date