



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT'S NAME: _____ SITE: _____ DOB _____ / _____ / _____ REGISTER# _____

I, or my authorized representative, request that health information regarding my care and treatment be released 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, as well as MENTAL HEALTH TREATMENT. Disclosure of CONFIDENTIAL HIV RELATED INFORMATION requires an additional authorization.
2. By authorizing the release of 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.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below.
4. I understand that signing this authorization is voluntary.
5. Information disclosed under this authorization might be redisclosed by the recipient.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE HVMH, Inc. TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY IDENTIFIED BELOW:
7. PLEASE INITIAL NEXT TO THE INDIVIDUAL OR ENTITY YOU WISH HVMH, INC. TO SHARE AND DISCUSS YOUR HEALTH INFORMATION WITH.

INITIAL:

- Mental Health Association of Ulster County- PO Box 2034, Kingston, NY 12401
Gateway Industries (Workforce One/PROS/CREATE)- 1 Amy Kay Pkwy, Kingston, NY 12401
Family of Woodstock- PO Box 3516, Kingston, NY 12401
Health Alliance Hospital- Kingston, NY 12401
Ulster County Probation- 733 Broadway, Kingston, NY 12401
Kingston City Court- 1 Garraghan Drive, Kingston, NY 12401
Pinegrove Center- 350 Washington Ave, Kingston, NY 12401
People, Inc.- 360 Aaron Court, Kingston, NY 12401
Institute for Family Health (New Paltz)- 279 Main St. Suite 102, New Paltz, NY 12561
Ulster County Department of Mental Health- 239 Golden Hill, Kingston, NY 12401
Ulster County Department of Social Services- 1061 Development Court, Kingston, NY 12401
Multi-County Community Development Corporation- 11 Twin Maples Plaza, Suite 5, Saugerties, NY 12477
ARCS- 138 Pine St. Suite 140, Kingston, NY 12401
RCAL- 727 Ulster Ave, Kingston, NY 12401
Willcare- 803 Grant Ave, Kingston, NY 12401
Always There Home Care- 918 Ulster Ave, Kingston, NY 12401

Other: Person/Agency _____ Title/Relationship: _____

Address: _____ Phone: _____

- 8. Specific information to be released:
[] Psychiatric Assessment [] Psychosocial Assessment [] Progress Notes [] Medication History [] Treatment Plans [] Attendance
[] Medical Record from (insert date) _____ to (insert date) _____
[] Entire Medical Record including progress notes, assessments, treatment plans, referrals, consults, billing records, insurance records, and records sent to you by other health care providers (excluding third party information).
[] Other: _____

- 9. Reason for release of information:
[] At request of individual [] Other: _____

- 10. My authorization is subject to revocation at any time (except to the extent that action has already been taken) and EXPIRES:
[] UPON MY REVOCATION OR SIX MONTHS FOLLOWING TERMINATION OF TREATMENT OR
[] ON THIS EVENT OR DATE: _____

Date: _____ Patient Signature: _____

OR

Patient's representative who is empowered to act on his/her behalf by reason of _____

Date: _____ Signature: _____

I have been offered/received a copy of this authorization: _____ (Please Initial)

[] REVOKED Effective Date: _____ Signature: _____