Finger Lakes COMMUNITY HEALTH *Taking the time to care.*	**Patient name:**
	Date of birth:
	Address:
	City: **State:** **Zip code:**

Authorization to Share Protected Health Information

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a clearly apparent or provable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I hereby permit the use or disclosure of the information as shown on page 2 to the Person/ Organization/ Facility/ Program(s) identified on page 2. I understand that:

1. Only the information described in this form (as shown on page 2) may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and all federal and state regulations as outlined below.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, mental health testing and/or treatment information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I understand that my substance use disorder records, as applicable, are protected under federal law, including the federal regulations governing confidentiality of substance use disorder patient records, 42. C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided by regulations.
5. I understand that my HIV status (as applicable), including testing, exposure to infections or related illnesses, or treatment for HIV/AIDs, is protected under Article 27-F of New York State Public Health Law and that my authorization must accompany any release of said information. For more information about HIV confidentiality, call the New York State Department of HIV Confidentiality Hotline at 1-800-962-5065.
6. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing and provided to Finger Lakes Community Health. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
7. I do not have to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment.
8. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524, 42 C.F.R. Part 2, and NYS Mental Hygiene Law §33.16.
9. For more information regarding federal privacy protection, I can call the Office for Civil Rights at 1-800-368-1019. I can also contact the NYS Division of Human Rights at 1-888-392-3644.

(Form continued on Page 2)

(Continued from page 1)

Patient name: **Date of birth:**

This information is requested by:

☐**the individual or his/her personal representative, or,**

☐**Other (please describe):** _____

The purpose of disclosure is (please describe): _____

☐ **Information to be released by Finger Lakes Community Health and sent to the individual or office listed below:**

☐ **Information to be received by Finger Lakes Community Health from the individual or office listed below:**

☐ **Information to be shared by Finger Lakes Community Health and other person or office for coordination of care:**

Finger Lakes Community Health, 601 B West Washington Street, Geneva, NY 14456

Email: healthinformation@flchealth.org Fax: 315-781-8444 Phone: 315-781-8448 (Option 3)

Information of other person, office, or doctor who will be releasing or receiving information:

Name:					
Address:					
City:		**State:**		**Zip code:**	
Phone:		**Fax**			
Email:					

Release Records via (must select at least one): ☐ **Mail** ☐ **Fax** ☐ **E-mail**

Date Range Being requested: From: To:

Specific information to be released:

☐ Discharge summary ☐ Pathology reports ☐ Tooth chart

☐ Laboratory results ☐ Consult reports ☐ X-Ray reports

☐ History and physical ☐ Immunization records ☐ X-Rays (dental)

☐ Progress notes ☐ Emergency room notes ☐ Itemized bills/payments

☐ Other (please describe):

Special Authorizations (Patient and/or patient representative initials must be present to release the specified information.) Review the informed consent section on page one (1) for information regarding these special authorizations.

_____ I authorize the release of my substance use disorder records in accordance with 42 C.F.R. Part 2 and HIPAA (45 C.F.R. Parts 160 and 164), as described in the informed consent on page 1 of this form.

_____ I authorize the release of my evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation neuropsychological information in accordance with NYS Mental Hygiene Law 33.13 in accordance with the informed consent on page 1 of this release form.

_____ I authorize the release of my testing, diagnosis or treatment for HIV/AIDS in accordance with HIPAA regulations and Article 27-F of New York State Public Health Law as stipulated in the informed consent on page 1 of this release form.

Name of person filling out this form: _____

Relationship to the patient: _____

Authorized signature: _____ Date_____

Received by: _____ Date: _____