Crouse MEDICAL PRACTICE

CROUSE MEDICAL PRACTICE
Neurosurgery
739 Irving Avenue Ste 600
Syracuse, NY 13210
PHONE: (315) 701-2550 **FAX: (315) 701-2551**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Patient Address	

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 6.
2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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 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 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure.

5. Name and Address of Provider or Entity authorized **to Release Your Information**:

6. Name and Address of Person(s) or Entity **to Whom Your Information Will Be Sent or Disclosed**:

7. Purpose for Release of Information: ☐ At request of patient ☐ Other:_____

8. **Time Period of Records** Check One: ☐ The request for information is limited to records commencing _____ and ending_____
Date Date

☐ Entire time period of records specified below

9. **Type of Information to be Disclosed** Check All that Apply: ☐ All CMP records ☐ Cardiology ☐ Endocrinology ☐ Neurology ☐ Psychiatry

☐ General/Bariatric Surgery ☐ Laboratory ☐ Neurosurgery ☐ Primary Care ☐ Pulmonology ☐ Spine and Pain Management

☐ Specific documents/parts of medical record (Ex: lab results) Specify:_____

☐ Entire medical record, including but not limited to: patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, immunizations, medications and prescriptions, and records sent to Crouse Medical Practice by other health care providers.

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[1]		
☐ HIV/AIDS-related information[2]		

10. Please select one of the following. I would like my records provided via: ☐Paper Format ☐Electronic Format (CD) ☐Verbal Format

☐ Fax. To #: _____ ☐ E-mail. E-mail address: _____

11. If not the patient, name of person signing form:	12. Authority to sign on behalf of patient:

13. Unless previously revoked by me, date or event on which this authorization will expire: _____

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. Please be advised for any patient access requests for his/her own medical records, **the following associated fees apply:** CD = $6.50; paper format = $0.90 flat fee plus reasonable and allowable labor costs, not to exceed $6.50. All other request types are subject to a different fee schedule.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW **DATE**

1. 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.
2. Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.