NYOH New York Oncology Hematology

Authorization for the Release of Health Information

Patient Legal Name _____ **DOB** _____ **Patient Account #** _____

Patient Address _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

1. This authorization may include disclosure of information relating to **alcohol and drug treatment, mental health treatment, confidential HIV/AIDS related information and genetic testing** only if I place my initials on the appropriate line in item 8. 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 8, 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 re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, genetic testing, or mental health treatment information, the recipient is prohibited from re-disclosing 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 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 generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
5. **Provider/Entity to Release this Information:** New York Oncology Hematology, PC

   Practice Address _____
6. **Name and Address of Person(s) to Whom this Information Can be Disclosed to:**

   _____

   _____
7. **Purpose for Release of Information** _____
8. **Unless previously revoked by me, the specific information below may be disclosed:**

   ☐ Indefinitely until revoked by me in writing **OR** ☐ From _____ (start date) Until _____ (end date)

   ☐ All health information (written and oral) except: _____

   For the following information to be disclosed to the party set forth above, please initial and indicate information to be disclosed:

   _____ Records from alcohol/drug treatment programs _____

   _____ Clinical records from mental health programs _____

   _____ HIV/AIDS related information _____

   _____ Genetic testing records _____
9. **Name of Person Completing Form (if not the patient)** _____

   Your Legal Authority to Sign on Patient's Behalf _____

I confirm that all sections of this form have been completed, any questions I had were addressed, and I have received a copy of the form upon request.

_____	_____	_____
Signature Patient / Legal Representative*	**Print Name**	**Date**

Witness Statement/Signature: *I have witnessed the execution of this authorization and state that I have provided a copy of the signed authorization upon request to the patient and/or the patient's authorized representative.*

_____	_____	_____
Witness	**Print Name**	**Date**