OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Irongate Family Practice Associates

Patient Name	Date of Birth	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: 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, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in item 9(a). 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(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, 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. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN TO WHOM IS SPECIFIED IN ITEM 9(b).**

7. ☐ FROM ☐ TO: Doctor/Facility _____

Address: _____

Ph ( ) _____ Fax ( ) _____

8. ☐ FROM ☐ TO: IRONGATE FAMILY PRACTICE ASSOC. 3 Irongate Center, Glens Falls, NY 12801 (518) 793-4409 Fax (518) 793-5886

9(a). Specific information to be released: ☐ Medical Record from (insert date) _____ to (insert date) _____

☐ The last three years of medical records, including the most recent Dexascan, Mammogram, Labs, EKG and chest x-ray, unless otherwise specified per below.

☐ Other: _____

Include: ***(Indicate by Initialing)*** _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV - Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with whom is listed here: (Name)_____

10. Reason for release of information:	11. Date or event on which this authorization will expire **or write "NONE"**
☐ At request of individual ☐ Transfer ☐ Other: ☐ Record Request	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

Irongate Family Practice Policy is to send the last 3 years Progress Notes, Lab & Radiology reports unless other specific information is requested. These copies are sent to the doctor's office the patient is transferring to.

No. of Pages Copied _____ By _____ **Copying Fee (75¢ per page)**_____ ☐ Paid by Cash ☐ Ck#_____

Date Release Form sent _____ Date Copies of Records sent_____

Irongate Family Practice Associates requests prepayment for records.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ **Date:**_____

Signature of patient or representative authorized by law.

*** 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.**