AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Health Information Departments (H.I.M):

☐ Buffalo Mercy Hospital #828-2322 Fax #828-3412
☐ Kenmore Mercy Hospital #447-6116 Fax #447-6269
☐ Home Care #706-2366 Fax # 706-0122
☐ Mount St. Mary's Hospital #298-2235 Fax #298-2111
☐ Sisters of Charity Hospital, St. Joseph Campus #891-2796 Fax #891-2448
☐ Sisters of Charity Hospital, Main St. Campus #862-1975 Fax #862-1879
☐ Other ____

Please note: There is no charge for records being released to a doctor or hospital. All other requests for medical records may be charged a fee, please contact the site Health Information Department for further information.

Patient Name: ______________________________ Date of Birth: ______________

Patient Street Address: ______________________________ Telephone #: (___) ______________

City, State & Zip Code: ____

This form authorizes the Catholic Health to disclose health information to the following recipient:

To: Business/Department/Office ____

Name of Person ____

Address/E-mail/Fax of Facility ____

Disclose:

☐Paper Record ☐Electronic storage device USB (if electronic record is available) ☐Records to be picked up ☐Fax
☐Email Secured ☐Email Unsecured ☐Direct Electronic Access (only available to CHS approved individuals and entities)

Authorization for direct electronic medical record access will <u>not</u> restrict access or disclosure to the minimum necessary. Therefore information on HIV, drug and alcohol treatment, and mental health notes if present may be accessed and disclosed.

Provide date(s) of service ____

☐Entire Record ☐Discharge Summary ☐Operative Report ☐Physician's Notes ☐X-Ray
☐Face Sheet ☐History & Physical ☐Pathology Report ☐Laboratory ☐Clinical Letter
☐Discharge Instructions ☐Other: ____

Purpose for the release of information: ____

This authorization is valid for one year unless otherwise indicated____

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to H.I.M. However, any revocation shall not apply to the extent that H.I.M. has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I am signing this authorization voluntarily.

Only ***ONE*** of the following sections must be completed.

This section is to be completed if authorization is being given by the Individual:

______________________________ ______________________________
Signature of Individual Date Signed

This section is to be completed if authorization is given by a Personal Representative:

______________________________ ______________________________
Name of Personal Representative: Signature of Personal Representative

______________________________ ______________________________
Date Signed Description of Authority to act as personal Representative of the Individual (e.g., Guardian, Attorney, Health Care Agent)

Initial here _______ for Authorization for Release of Health Information (including Alcohol/Drug Treatment & Mental Health Information) and Confidential HIV/AIDS Related Information and complete page 2 and 3.

In the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (45 CRF Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
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 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, 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 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 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. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: ____________ (INSERT START DATE) until ____________ (INSERT EXPIRATION DATE OR EVENT)

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

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*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

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.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW ____________ DATE ____________

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

STAFF PERSON'S NAME AND TITLE ____________ SIGNATURE ____________ DATE ____________

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: 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.

DOH-5032 (4/11)

Authorization for Release and Exchange of Health and Behavioral Health Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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

1. This authorization may include disclosure of all of my health information, including where applicable, any and all information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT including CLINICAL RECORDS*, GENETIC, FAMILY PLANNING and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the entities indicated in Item 6.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment including Clinical Records*, Genetic, and/or Family Planning information, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further 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 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. Name and Address of Provider or Entity Releasing and Exchanging this Information:

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

I authorize the above listed Entity to contact the BHO Coordinator listed below to inform them of my enrollment in this treatment program and facilitate the coordination of the physical and behavioral health care services that I require. So that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and the following entities relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services: the New York State Department of Health; Office of Mental Health; Office of Alcoholism and Substance Abuse Services; any subsequent treatment facility or BHO Coordinator to which I may be referred; and

Behavioral Health Organization (BHO) Coordinator: ______________________________
Managed Addiction Treatment Services (MATS) Coordinator: ______________________________
Local Governmental Mental Hygiene Agency: ______________________________
Other Case Manager (i.e., ACTS): ______________________________
Other: ______________________________

7. The Purpose of this disclosure is to allow authorized entities to communicate with each other to facilitate the coordination of my behavioral health services, integration of my physical health services and evaluation of provider performance.

8. My health information may be disclosed and exchanged for a period of three (3) years from last the date of service, or until revoked.

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

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.

____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

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

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STAFF PERSON’S NAME AND TITLE SIGNATURE DATE

This form has been approved by the NYS Department of Health, NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information.

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: 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.

TRS – 51 (12/2011)