Nephrology Associates of Syracuse, PC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Full Name:	**Patient Date of Birth:**

Patient's 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 Privacy Rule of the Health Information Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosures 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 information described below includes any of these types of information, and I initial the line on the box Item 9(a), I specifically authorize release of such information to the person(s) indicted 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 re-disclosing 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 Nephrology Associates of Syracuse, PC 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 re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure 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 THEN THE INDIVIDUAL OR ORGANIZATION SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release information: **NEPHROLOGY ASSOCIATES OF SYRACUSE, PC**
8. Name and address of person or organization to whom this information will be sent:

9. **(a) Specific information to be released - Please check below and fill in blanks as applicable:**

- o Medical Records from (insert date)__________________________ to(insert date) __________________________
- o Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology films, referrals, consults and billing records
- o Other:____________________________________

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Include:
_________Alcohol/Drug Treatment
________Mental Health Information
_________HIV- Related Information

9. **(b). Authorization to Discuss Health Information**

By initialing here _________ I authorize **NEPHROLOGY ASSOCIATES OF SYRACUSE, PC** to discuss my health information with:

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(Person or Organizations Name)

10. **Reason for release of information- Please check below and complete:** o At request of Individual o Transfer Care to another practice o Other: ____________________________________ ____________________________________	11. **Date or event on which this authorization will expire:**
12. **If not the patient, name of person signing form**:	13. **Authority to sign on behalf of patient:**

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 this form.

____ **Date:** ____________________

Signature of patient or representative authorized by law

Revised 12/31/13; 11/3/15