Northwell Health®

# Authorization for Release of Health Information Pursuant to HIPAA

| PATIENT NAME (PRINT) | DATE OF BIRTH |
|---|---|
| PATIENT ADDRESS (PRINT AND INCLUDE APT#) | TELEPHONE NUMBER |
| | EMAIL ADDRESS |

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed 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 8(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 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol, drug treatment, or mental health related 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. Name and address of health care provider or entity to release this information:
Peconic Bay Medical Center 1300 Roanoke Ave. Riverhead, NY 11901 Phone#: 631-548-6361 Fax#:631-548-6369

6a. If you are requesting only laboratory results directly from Northwell Health Laboratories, enter "Northwell Health Laboratories" above. Provide the following information and then go directly to Sections 8, 10, 11, 12 and 13 and sign as indicated below item 13.

Ordering Physician's Name: _____
Information to Be Released: Laboratory testing results
Date Of Service: _____/_____/_____

| Authorized Recipient: | ☐ Patient | ☐ Patient's Designee (or parent of unemancipated minor patient) Name of Designee _____ Relationship _____ |
|---|---|---|

☐ Consulting Physician: Name: _____ Telephone: (_____) _____
Address: _____

The laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of laboratory results. All questions regarding testing and the results will be answered by the PATIENT'S PHYSICIAN ONLY. Reports will generally be available 4 days after ALL laboratory test result are complete.

Result option (select one) _____ ☐ Mail _____ ☐ Fax _____ ☐ Pick-Up (at any Patient Service Center)

Patient or Representative Initials: ☐



**Copy 1 – Patient Medical Record**
**Copy 2 – Patient or Patient's Personal Representative**

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| 7. Name, address, telephone and fax numbers of person(s) or category of person to whom this information will be sent: | |
|---|---|
| Full Name (Print): | Phone #: |
| Full Address (Print and include Apt or Suite #): | Fax #: |
| | Email Address: |

8. (a).Specific information to be released:

☐ Medical Record Abstract ☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Designated Record Set ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.

☐ Other: _____

_____

Include: (Indicate by initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Related Information**

_____ **HIV-Related Information**

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

☐ By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with the individual listed: _____

Individual Name

| 9. Reason for release of information: ☐ At request of individual ☐ Other: _____ | 10. Date or event on which this authorization will expire: |
|---|---|
| 11. Printed name and signature of person signing form: | 12. Authority to sign on behalf of patient or relationship to 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 the form.

_____ _____ _____ _____

Patient/Agent/Relative/Guardian* (Signature) Date / Time Print Name Relationship if other than patient

_____ _____

Telephonic Interpreter's ID # Date / Time

**OR**

_____ _____ _____ _____

Signature: Interpreter Date / Time Print: Interpreter's Name and Relationship to Patient

_____ _____ _____ _____

Witness to signature (Signature) Date / Time Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

*** 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.**

**Internal Use Only - Student Immunization Authorization** Consent provided by

Consent provided by: _____ Relationship to Patient: _____

Name of HIM Staff Member who obtained verbal consent: _____ Date Processed: _____

Internal Use Only - For Northwell Health Laboratories Use Only:

Date: ____/____/____; Time: ____:____; Personnel Name: _____; Accession #: _____



VD001 (8/24/17)

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## Electronic Communication Consent:

If you choose to request your record via e-mail, Northwell Health asks that you acknowledge and consent to the following:

Unless I specifically request otherwise, e-mails sent to me from Northwell Health will be encrypted to keep them secure during transmission. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails and, therefore, e-mails that I send from my email account may not be protected from inappropriate access by others via hacking or other means. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to transmit my personal health information via e-mail.

I further acknowledge that e-mails may be inadvertently sent to the wrong address and subject to technical malfunctions. Therefore, I understand that e-mail delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that I or my healthcare provider can terminate e-mail communication services at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or if my e-mail address has changed.

| | | | |
|---|---|---|---|
| Patient/Agent/Relative/Guardian* (Signature) | Date / Time | Print Name | Relationship if other than patient |
| Telephonic Interpreter's ID # **OR** | Date / Time | | |
| Signature: Interpreter | Date / Time | Print: Interpreter's Name and Relationship to Patient | |
| Witness to signature (Signature) | Date / Time | Print Witness Name | |

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

**Request for Email Communication via Unencrypted Email <u>Only</u>**

Northwell strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

| | | | |
|---|---|---|---|
| Patient/Agent/Relative/Guardian* (Signature) | Date / Time | Print Name | Relationship if other than patient |