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]

Patient Name	Date of Birth:	Social Security Number
Patient Address:		
I, or my authorized representative, request that health information regarding	g my care and treatment be releas	ed as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Hea	Ith Insurance Portability and Acc	ountability Act of 1996 (HIP

AA), 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 ifl 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

8. Name and address of person(s) or category of person to wh	hom this information will be sent:
9(a). Specific information to be released:	
☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient historie	to (insert date)————————————————————————————————————
Other: Authorization to Discuss Health Information	Include: (Indicate by Initialing)Alcohol/ Drug TreatmentMental Health InformationHIV-Related Information
	AYHTC / HANYS Health Center, Inc. Tame of individual, agency, health care provider Tamental agency, listed here:
to discuss my hearth information with my attorney, or a gover	innental agency, noted here.
10. Reason for release of information: At request of individual	II. Date or event on which this authorization will expire:
10. Reason for release of information:	
10. Reason for release of information: At request of individual Other: 12. If not the patient, name of person signing form:	Il. Date or event on which this authorization will expire:

* 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.