

## Authorization for Release of Health Information Pursuant To HIPAA

PATIENT NAME (PRINT)	DATE OF BIRTH
PATIENT ADDRESS AND TELEPHONE NUMBER	

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:
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6a. If you are requesting only laboratory results directly from North Shore-LIJ Laboratories, enter "North Shore-LIJ Laboratories" above. Provide the following information and then go directly to Sections 7, 9, 10, 11 and 12 and sign as indicated below item 12.

Ordering Physician's Name: _____	
Information to Be Released: <u>Laboratory testing results</u>	
Date Of Service: ____ / ____ / ____	
Authorized Recipient:	<input type="checkbox"/> Patient <input type="checkbox"/> Patient's Designee (or parent of unemancipated minor patient) Name of Designee _____
<input type="checkbox"/> 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:

