

4. Is information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse being requested?

Yes (Attach special authorization form)

No

5. This information is being requested for the following purpose:

Pursuant to the patient's authorization (Attach Patient Authorization form)

For a purpose that does not require patient authorization; specify below:

Treatment purposes

Payment purposes

Required by law

Public health activities

Health oversight activities

Judicial and administrative proceedings

Avoiding serious threat to health or safety

Specialized government functions

Worker's compensation

Other; specify _____

6. Date Information is Needed: _____

As a covered entity under HIPAA, SUNY Downstate Medical Center is aware that this information may be not be re-disclosed, unless permitted to do so under state or federal law. SUNY Downstate Medical Center certifies that any patient authorizations attached are valid, to the best of its knowledge, and that the information requested is the minimum amount necessary to accomplish the specified purpose.

Print Name Of SUNY Downstate Staff Member

Date

Department

Telephone Number