



## AUTHORIZATION FOR RELEASE OF INFORMATION

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. A representative of University Physicians of Brooklyn, Inc., is available to answer any questions regarding this authorization.

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: \_\_\_\_\_ (Day) \_\_\_\_\_ (Eve)

1. Persons/Organizations disclosing the information: \_\_\_\_\_

2. The information may be disclosed to and used by the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

3. Information to be disclosed:

Complete Outpatient Medical Record

Partial Outpatient Medical Record:

Period(s) of treatment from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

History & Physical Examination

Progress Notes

Consultation Reports

Test Results - specify: \_\_\_\_\_

Other - specify: \_\_\_\_\_

4. New York State regulations [NY Public Health Law §2782(1)(b)] require a special authorization for release of 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.

Do not authorize release of this information.

Authorize release of this information; specify the information to be released \_\_\_\_\_

(Cont'd)

