UNIVERSITY PHYSICIANS
BROOKLYN, INC.

# AUTHORIZATION FORM

*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: _____ MR#: _____

Address: _____

_____

DOB: _____ Telephone#: _____ (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:

___ A. Complete Outpatient Medical Record

___ B. 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 _____

_____

5. This information is being used or disclosed for the following purpose:

_____

_____

_____

I understand that this authorization will expire 6 months from the date this form is signed, unless otherwise stated below:
Expiration Date/ Event: _____

*By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.*
*If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.*
*You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign this form.*
*You have a right to receive a copy of this form after you sign it.*
*You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to:*
*University Physicians of Brooklyn, Inc.*
*_____ Practice*
*450 Clarkson Ave.*
*Brooklyn, NY 11203*

By signing below, I acknowledge that I have read and accept all of the above.

_____ _____
Print Name Of Patient Signature of Patient

_____
Date

If you are signing as a personal representative of the patient, read and sign below:

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____ and that I have the lawful provisions set forth in this authorization and agree to the use and/or disclosure of the patient's information for the purposes set forth herein.

_____ _____
Print Name Signature

_____
Date