DOWNSTATE
HEALTH SCIENCES UNIVERSITY

HIPAA AUTHORIZATION FORM

I.		
Person/organization disclosing the information:		
II.		
Patient Last Name, First Name:	Maiden or Other Name:	Patient Date of Birth:
Patient Address:		
City, State & Zip:	Telephone: (Area Code and #)	Medical Record Number:

By initialing here _____, I authorize SUNY Downstate Health Sciences University to discuss my health information with the following individual.

Name, address and telephone number of person or entity to whom this information will be sent:

- ☐ Check here if same as above.
- ☐ Check here if the person or entity is another healthcare provider.

Name: _____

Address: _____

Phone #: _____

III.

Specific information to be released:

- ☐ Medical record from (insert date) _____ to (insert date) _____.
- ☐ Entire Medical Record, including patient histories, office notices (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other _____

IV.

New York State regulations (NY Public Health Law S 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 you want the following types of records included: *(indicate by checking the box and initialing)*

- ☐ Alcohol and Drug Treatment _____
- ☐ Mental Health Information _____
- ☐ HIV-Related Information _____

V.

This information is being used or disclosed for the following purposes:	☐ Patient Request ☐ Treatment ☐ Insurance/ Payment	☐ Legal ☐ Government Benefits ☐ Other:

HIPAA AUTHORIZATION FORM- PAGE 2

VI.

What type of access are you requesting?

- ☐ Schedule physical inspection of records
- ☐ Obtain summary of records
- ☐ Obtain explanation of records
- ☐ Obtain copy of the records (paper or electronic)- specify method of delivery / format below:

◯ Pick up	◯ Send by mail	◯ CD
◯ Regular email*	◯ Encrypted email	◯ USB Drive
		◯ Paper

If requesting records to be emailed, please specify email address: _____

**Regular, un-encrypted email is not secure and could result in your medical records being intercepted, read and copied during transmission or while being stored in your inbox. By signing this notice, you are acknowledging that you're aware of and accepting the risk by requesting your medical records to be sent via regular email.*

VII.

Fees: Photocopies: $0.39/page for first 200 pages; $0.12/page for pages 201-400; Free for >400 pages.
Electronic media/ Email: Flat fee of $6.50
Mammograms: Flat fee of $6.50
Summaries/ Explanations: Dependent upon number of hours and physician hourly consult rate.
(Fees do not apply to requests for medical records in support of an application for government benefits).

VIII.

- 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 and 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 the 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 submit or revoke this authorization, please write to:
  SUNY Downstate Health Sciences University
  Health Information Management Department
  450 Clarkson Avenue, MSC #119
  Brooklyn, NY 11203
  HIMROI@downstate.edu
- A Federal, State, Local or other Government issued photo ID must be submitted to HIM with this completed form.

IX.

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

X.

By signing below, I certify that I am requesting access to my health information in the manner described above and I will be contacted about fees prior to the execution of my request for medical records.

Print Name of Patient/Personal Representative	Signature of Patient/Personal Representative
Description of Personal Representative's Authority	Date