

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	Home Phone:
		Office Phone:
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released 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. I have the right to revoke this authorization at any time by writing to _____ at the address listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. 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.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

4. Name and address of health provider or entity to release this information:	
5. Name and address of health provider or other person(s) to whom this information will be sent: PALISADES PULMONARY & MEDICAL, P.C. 2 Medical Park Drive, Suite 3 West Nyack, New York 10994	
6. Specific information to be released: <input type="checkbox"/> All records and reports <input type="checkbox"/> Lab report(s) dated _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Records and reports from _____ to _____	
7. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	8. Date or event on which this authorization will expire: <input type="checkbox"/> _____ OR <input type="checkbox"/> INDEFINITE unless revoked or terminated by the patient or the patient's authorized representative.
9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Patient or Representative Authorized By Law: _____ Date: _____

Witness: _____

NOTE: THIS AUTHORIZATION IS **NOT** INTENDED TO AUTHORIZE DISCLOSURE OF INFORMATION RELATING TO ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT, AND CONFIDENTIAL HIV RELATED INFORMATION.