ORCHARD PARK FAMILY PRACTICE
SERVICE · COMPASSION · ACCOUNTABILITY
3670 SOUTH BENZING RD STE A • ORCHARD PARK, NY 14127
(716) 662-5357 • FAX 662-2774

OCA Official Form No. 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: DOB:

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 understandthat:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. 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.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**
7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Orchard Park Family Practice, PC drrichardruh@opfp.medentdirect.com

9(a): Specific information to be released:
☐ Medical Record from/to date:
☐ Entire Medical Record, Including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, and records sent to you by other health care providers.
☐ Other: Last year progress notes, labs, consults and imaging, last mammogram, pap, DEXA and colonoscopy, immunization and medication list
Include: *(Indicate by initialling)*. You MUST initial if you have any of the following information in your medical records. If you DO NOT initial, the medical office will not be permitted to release your records.
☐ Alcohol/Drug Treatment
☐ Mental Health Information
☐ HIV-Related Information

Authorization to Discuss Health Information
(b) ☐ By initialling here: _____ I authorize _____
(Name of Individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name):

10. Reason for release of information:
☑ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:
12 MONTHS FROM DATE OF SIGNATURE

12. If not the patient, name of person signing from: _____
13. Authority to sign on behalf of patient: _____

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

_____ _____
Signature of patient or representative authorized by law. Date

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects Information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**