Authorization for Release of Information

Name _______________ ______________________ **Identification #**_____________________

Address ______________________ City _________________ State ________ Zip Code _____________

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) to:

☐ **Use the following protected health information, and/or** ☐ **Disclose the following protected health or other information to:**

Name and Address of health provider or entity to release this information: ______________________________

____

Name and Address of person (s) or category of person to whom this information will be sent: _______________

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Possibility of Re-disclosure: It is possible that the person or organization you have named to receive this information may re-disclose the information and if so, the information may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific information to be released:

- ☐ **Medical Records**
- ☐ **Treatment Records**
- ☐ **Diagnostic Records**
- ☐ **Other:**____
- ☐ **School Records**
- ☐ **Payroll Records**
- ☐ **State Agency Records (NYSCB/etc.)**
- ☐ **City Agency Records (DFTA, etc.)**

This protected health or other information is being used or disclosed for the following purposes: ____________

____

I understand that my authorization will remain in effect from the date of my signature until ________, and that the information will be handled confidentially in compliance with all applicable federal, state and city laws.

Terms for Termination/Revocation: You have the right to revoke the authorization at any time. However, your revocation will not affect any use or disclosure that we made in reliance upon your authorization before we learn of your revocation. You may revoke the authorization by writing to Sister W.E.L.L.S. at sisterwells17@gmail.com

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.

I authorize release of the above-specified information.

____ _______ ______________________________

Signature Name of Client or Guardian **Date** **Printed Name of Client or Guardian**

If the person signing the form is not the individual whose information is being disclosed, please indicate your relationship to that person:

☐ **Parent or legal guardian of a child under the age of 18.**

☐ **Personal Representative (please attach documentation, ie. Power of Attorney, Court Order, Health Care Proxy).**