For Office Use Only:	**Mailed** ☐ -or- **Faxed** ☐	Date:	Initials:

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

Patient Name:	Date of Birth:
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 (HIPPA), I understand that:

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 disclosing 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 disclosed by the recipient (except as noted above in Item 2), and this disclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENT AGENCY SPECIFIED IN ITEM 9(b)**

7. Name and address of the health provider or entity to release this information:
Full MD Name & Address>>

8. Name and address of person(s) or category of person to whom this information will be sent:
Amherst Medical Associates LLP- 6000 N. Bailey Ave Ste. 1D Amherst, NY 14226 (P) 716-834-4266 (F) 716-834-6255

9 (a). Specific information to be released:

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

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____
initials (Name if individual health care provider)
to discuss my health information with my attorney, or government agency, listed here:
_____
(Attorney/Firm Name or Government Agency Name)

10. Reason for release of Information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	**6 Months from date of signature**
12. If not the patient, name of person signing form:	13. 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: _____ Date: _____