HIPAA Authorization for the Release of Health Information

Patient Name: _____ Patient DOB: _____

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. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information **UNLESS** I place my initials on the appropriate line in below indicating this type of information should **NOT** be sent.
2. If I am authorization 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 with 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)480-2493or 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 heath care provider listed below. I understand that I 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 the disclosure.
5. Information disclosed by this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZATION YOU TO DISCUSS MY HEALTH INFORMAITON OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDICATED RECIPIENT BELOW.

I am hereby granting WorkFit Medical, PLLC to

☐ Obtain ☐ Release

To/From the below entity

_____ _____

Facility Name Phone Number

_____ _____

Address Fax Number

_____ _____

City, State, Zip Code Email Address

The below information

☐ All medical records on file
☐ All diagnostic reports
☐ All immunization and lab reports
☐ Medical records related to claim or current exam ☐ including diagnostic reports
☐ Other: _____

Information should be released from the below dates

☐ All
☐ Beginning _____ and ending _____

Initial below any information you do NOT want included:

_____ Alcohol/Drug Treatment
_____ Mental Health Treatment
_____ HIV- Related Information

This authorization will remain in effect for the duration of my employment with the above named company or for 5 year unless otherwise indicated here: _____

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 this form.

Signature: _____ Date: _____

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