AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PG 1 OF 3)

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Name:
Med. Rec. #: *Date of Birth:* *Age:*
Visit #: *Insurance:*
Service Date: *Service Time:* *Room:*

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law 45 C.F.R. parts 160, 164. Except as otherwise permitted or required by the privacy law, a healthcare provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R., Section 164.508.

Patient/Resident Name: _____ Date of Birth:_____

Address: _____

Phone: _____

E−Mail address: _____

_____ Please initial here if you would like your records electronically
(initials)

I hereby authorize the use or disclosure of protected health information as follows:

1. The information that may be used or disclosed includes (initial applicable line):

_____ All treatment records. (If this is initialed, patient must also separately initial the categories
(initials) below if Behavioral Health records, Drug and Alcohol Treatment records and/or HIV−related records are to be used or disclosed.)

_____ Record of treatment during the following time period:
(initials)

_____ **Behavioral Health/Psychiatric records,** discharge summary and information below:
(initials)

_____

_____

_____

If you authorize the release of behavioral health information, the disclosing party named above will disclose such information in accordance with Sections 33.13 and 33.16 of the Mental Hygiene Law.

_____ **Drug and Alcohol Treatment records,** discharge summary and information indicated below:
(initials)

_____

_____

_____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PG 2 OF 3)

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Name:
Med. Rec. #: *Date of Birth:* *Age:*
Visit #: *Insurance:*
Service Date: *Service Time:* *Room:*

It is understood that any disclosure is bound by 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records and that re−disclosure of alcohol and drug abuse information to a party other than the one designated above is forbidden without your additional written authorization. If this authorization involves alcohol and drug abuse patient information, it shall expire six (6) months from the date signed, unless a different time period, event or condition is specified in Section 2 below. NOTE: Any information disclosed through this form will be accompanied by Form ALC 440 Prohibition on Redisclosure of Insurance Concerning Alcoholism Patient.

_____ (initials) **HIV−Related records,** discharge summary and information indicated below:
Due to NYSDOH Chapter 308 of the Laws of 2010 HIV testing Law Mandated August 2010, all patients should be asked to initial this section

_____

_____

_____

If you authorize the release of HIV−related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV−related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV−related information without authorization. If you experience discrimination because of the release or disclosure of HIV−related information, you may contact the New York State Division of Human Rights at (212) 480−2493 or 1−800−523−2437 or the New York City Commission on Human Rights at (212) 306−7450. These agencies are responsible for protecting your rights.

_____ (initials) **Other records** (describe):

_____

_____

2. This authorization expires (initial applicable line):

_____ (initials) on _____ (date)

or

_____ (initials) upon the following event _____

3. This information may be disclosed by:

Erie County Medical Center or _____
(Name of the person or entity, or class of persons, that will disclose information)

4. This information may be disclosed to:

_____

_____
(Name of person(s) or class of persons or agencies and complete address and phone number)

5. The purpose of disclosure is:

_____ (initials) Request of the individual who is the subject of the record or his/her personal representative;

_____ (initials) Other (describe) _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PG 3 OF 3)

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Name:
Med. Rec. #: *Date of Birth:* *Age:*
Visit #: *Insurance:*
Service Date: *Service Time:* *Room:*

6. It is understood that this authorization may be revoked. To revoke this authorization, a written request should be made to the facility s Privacy Officer at the address stated below. Information disclosed before an authorization is revoked may not be retrieved. If action was taken in reliance on the authorization, the person who relied on the authorization may continue to use or disclose protected health information as needed to complete the work that began because the authorization was given. To revoke this authorization, please write to:

Erie County Medical Center
462 Grider Street
Buffalo, NY 14215
Attn: Privacy Officer

Terrace View Long Term Care Facility
462 Grider Street
Buffalo, NY 14215
Attn: Privacy Officer

7. It is understood that information used or disclosed pursuant to this authorization (other than Drug and Alcohol Treatment records, HIV−related records and Behavioral Health records) may be re−disclosed by the recipient of the information. Most healthcare providers and all health benefit plans must follow federal rules protecting the privacy of health information. Those rules do not apply to other organizations.

8. You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare, and your healthcare benefits will not be affected if you do not sign this form.

9. You have a right to see and copy the information described on this authorization form in accordance with facility policies. You also have a right to receive a copy of this form after you have signed it.

Do *not* sign a blank form. (You or your personal representative should read and complete this form before signing.)

Patient Request

1. If the patient is a minor over the age of twelve, the patient may be informed of this request prior to granting the review.
2. The treating physician will be informed of this request. The treating physician may grant access to a prepared summary of this information if, in her/his opinion, the review may endanger my life or physical safety or may cause substantial harm to others.
3. The cost is $.75 per page.

Signature

Print Name of Patient or Personal Representative Date

Description of Personal Representative's Authority

Facility Witness (for disclosure of all records)