



45350

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

Patient Name: _____

Patient Address: _____

Patient Date of Birth: _____ SSN: _____

Medical Record Number: _____ Maiden or Other Name _____

I hereby authorize (check center) or other Healthcare Provider (specify):

Columbia Presbyterian Medical Center New York Weill Cornell Medical Center Westchester Division Other _____

To release (check one) Protected Health Information and/or Sensitive Protected Health Information (see reverse side for definitions) pertaining to my:

Hospital admission (date) _____ Outpatient visit (date) _____

Emergency Department visit (date) _____ Ambulatory/Outpatient admission (date) _____

I authorize disclosure of the following information from my medical record (check where applicable list type and date):

Immunization _____ Lab Reports _____ Radiology and imaging reports _____

Discharge Summary _____ Clinical Documentation _____ Pathology Reports _____

Other (describe) _____

From my medical records to:

Name of organization or person: _____

Address: _____ Apt. # _____

City _____ State _____ Zip Code _____

Telephone (Area Code and Number): _____

The purpose(s) for which disclosure is authorized (check where applicable):

Medical Care Insurance Immunization Other (specify) _____

I understand that:

1. Treatment and payment will not be conditional on whether I provide Authorization for any requested disclosure by NewYork-Presbyterian Hospital.
2. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee.
3. This Authorization is voluntary and that I have the right to refuse to sign it.
4. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by NYPH in reliance on this Authorization before receipt of my written revocation.
5. **This Authorization will expire on _____ / _____ / 20_____ (fill in date if less than 1 year) or 1 year after being signed.**
6. The information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
7. My medical records may contain genetic testing information including test results.
8. **This authorization is also applicable to patients with drug or alcohol related diagnoses, protected by Title 42 of the Code of Federal Regulations. (see reverse side for description)**

_____/_____/20_____
Signature of patient/personal representative (e.g., legal guardian) Date

If personal representative, relationship to patient, print name

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court.)

538498 (10/03)

DEFINITIONS

1. "Protected Health Information" (PHI): is information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.
2. "Sensitive Protected Health Information" (SPHI): means Protected Health Information that pertains to (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS*, (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

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FOR PATIENTS WITH DRUG OR ALCOHOL RELATED DIAGNOSES

1. I am informed that Title 42 of the Code of Federal Regulations protects the confidentiality of the records of patients with alcohol and drug-related diagnoses.
 2. According to Title 42 any person who receives information from the record of such a patient may not show this information to anyone else without my written permission.
 3. Any information released with written permission, will be accompanied by a statement, which tells the person who receives the information that he may not show this information to anyone else, unless I give my permission in writing.
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Medical Correspondence Units

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525 East 68th Street, F-041
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(212) 746-0530

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Morgan Stanley Children's Hospital (CHONY)
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New York, NY 10032
(212) 305-6031

NewYork Weill Cornell Medical Center
Westchester Division
21 Bloomingdale Road
White Plains, NY 10605
(914) 997-5725