Planned Parenthood®
Care. No matter what.
Planned Parenthood Hudson Peconic

Huntington	755 New York Avenue	Huntington 11743	phone: (631) 427-7154	fax: (631) 427-1381
Mount Vernon	6 Gramatan Ave., Ste 404	Mount Vernon 10550	phone: (914) 668-7927	fax: (914) 668-7967
New Rochelle	150 Lockwood Ave., Ste LL-1	New Rochelle 10801	phone: (914) 632-4442	fax: (914) 632-4625
Patchogue	450 Waverly Avenue	Patchogue 11772	phone: (631) 475-5705	fax: (631) 289-6484
Riverhead	877 East Main St., Ste 109	Riverhead 11901	phone: (631) 369-0230	fax: (631) 369-5582
Smithtown	70 Maple Avenue	Smithtown 11787	phone: (631) 361-7526	fax: (631) 361-7678
Spring Valley	25 Perlman Dr.	Spring Valley 10977	phone: (845) 426-7577	fax: (845) 426-6006
West Islip	180 Sunrise Highway	West Islip 11795	phone: (631) 893-0150	fax: (631) 893-0146
White Plains	175 Tarrytown Road	White Plains 10607	phone: (914) 761-6566	fax: (914) 948-5533
Yonkers	20 South Broadway, 11th fl.	Yonkers 10701	phone: (914) 965-1912	fax: (914) 965-8129

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		Phone

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** 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 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 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 redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PERSONS OR AGENCY LISTED BELOW.**

7. Name and address of health provider or entity to release this information:
Planned Parenthood Hudson Peconic, 570 Taxter Rd, Suite 250, Elmsford, NY 10523 (Check location at top)

8. Name and address of person(s) to whom this information will be disclosed:

9(a). Specific information to be released:

☐ Medical Record from *(insert date)* _____ To *(insert date)* _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, and records sent to you by other health care providers.

☐ Other: _____ Include: *(Indicate by Initialing)*

_____ _____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

Authorization to Discuss Health Information _____ **HIV-Related Information**

(b). ☐ By initialing here _____ I authorize Planned Parenthood Hudson Peconic to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information? ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
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 of patient or representative authorized by law Date

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protect information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Patient Name	Date of Birth	Social Security Number
Patient Address		Phone

For Office Use Only:
Date Request Filled: _____ By: _____
Identification Presented: _____

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