AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

1. **Patient's Name**: _____
First Name Last Name

2. **Patient's Date of Birth**: ____/____/____

3. **Date Authorization Initiated**: ____/____/____

4. I authorize the healthcare practitioner: [Name of practitioner]

_____
(the 'Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below, to:

_____
[Name of person(s) authorized to receive the disclosure]

5. I am hereby authorizing the disclosure of the following protected health information:

_____

_____
[Describe the protected health information to be disclosed e.g., diagnostic and treatment progress information]

6. This protected health information is being used or disclosed for the following purposes:

☐ At my request.

☐ Other (describe): _____

7. I specifically authorize the disclosure by the healthcare practitioner of the following types of protected health information by placing my initials where appropriate below, my initials serving as my signature release for each type of specially protected health information:

_____Psychotherapy Notes (as defined by HIPAA) [1]

_____Confidential HIV Related Information [2]

_____Alcohol/Substance Abuse Treatment Information [3]

8. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and /or disclosure of my confidential protected health information.

_____ _____
Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

_____ _____
Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient — Relationship to Patient (if Personal Representative)

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

[1] HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

[2] HIV is the Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts, including HIV test results. 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. Although I am authorizing this release of HIV-related to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.

[3] Although I am authorizing this release of Alcohol/Substance Abuse treatment information to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: 1025 Northern Blvd., Ste 214, Roslyn, NY 11576.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.