

Social Security Number



Patient Name

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA. [This form has been approved by the New York State Department of Health]

Date of Birth

			10年至11年11日
Patient Address	1	744-57-95-4	20 11 11
I, or my authorized representative, request that health inform	ation regarding my care	and treatment be rele	ased as set forth on this form:
In accordance with New York State Law and the Privacy Rul			
(HIPAA), I understand that:		A COLUMN TO A STATE OF THE STAT	eria was bijika ca
1. This authorization may include disclosure of informati TREATMENT, except psychotherapy notes, and CONFIDI the appropriate line in Item 9(a). In the event the health infinitial the line on the box in Item 9(a), I specifically authorize 2. If I am authorizing the release of HIV-related, alcohol oprohibited from redisclosing such information without my understand that I have the right to request a list of people who I experience discrimination because of the release or disclosure of Human Rights at (212) 480-2493 or the New York Cit responsible for protecting my rights. 3. I have the right to revoke this authorization at any time is revoke this authorization except to the extent that action has a 4. I understand that signing this authorization is voluntary benefits will not be conditioned upon my authorization of this 5. Information disclosed under this authorization might be redisclosure may no longer be protected by federal or state law	ENTIAL HIV* RELATIONMANTH TO THE PROPERTY OF T	ED INFORMATION w includes any of the stion to the person(s) intal health treatment ermitted to do so u red HIV-related information, I may contact in Rights at (212) 30 care provider listed be it on this authorization ont, enrollment in a pient (except as note	N only if I place my initials on set types of information, and I indicated in Item 8. It information, the recipient is under federal or state law. I ation without authorization. If the New York State Division 06-7450. These agencies are elow. I understand that I may a. health plan, or eligibility for ed above in Item 2), and this
6. THIS AUTHORIZATION DOES NOT AUTHORIZE			
7. Name and address of health provider or entity to release the	is information:	e, ath Pto	NU 10010
8. Name and address of person(s) or category of person to wh	OCK FACT ?	2nd St. 18	+ 91001 NU 10010
9(a). Specific information to be released:	to (insert date) fice notes (except psycho, and records sent to you) EVN'I LEV COLL Name of indi	Include: (Indicate of Alcohol Mental HIV-R	esults, radiology studies, films, providers, by Initialing) I/Drug Treatment Health Information elated Information
(Attorney/Firm Name	or Governmental Agency N	(ame)	
Reason for release of information: At request of individual Other:	11. Date or even	t on which this autho	
12. If not the patient, name of person signing form:	13. Authority to	sign on behalf of pat	ient:
All items on this form have been completed and my questions copy of the form.		en answered. In addit	ion, I have been provided a
Cincolness of noticed as someone to be a subspiced by their	Date:		
Signature of patient or representative authorized by law.			

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.