Patient Authorization For Use And Disclosure of Protected Health Information

(Release of Records or Information)

Consistent with our Privacy Policy, we must obtain your informed, written authorization before we use or disclose your protected health information. Please read carefully and fill out completely.

Date: _____

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

I, _____, authorize Primary Care of WNY, LLP to obtain or disclose requested medical records on my behalf.

Who will disclose the information? (Name/address of person or facility that you authorize to disclose the information - where are the records/information coming from - generally a previous physician or another physician that treats you.)

_____
_____
_____.

Who will use and/or receive the information? (Name/address of person or facility that will receive the information - who will receive the records/information - generally your new physician or another physician that treats you.)

Provider: _____

What information will be used or disclosed? (Check the appropriate item below and describe if necessary.)

☐ A copy of my medical records to include only the following: last 2 years of progress notes, labs, tests, and physical exams, last EKG, last mammogram, last colonoscopy, entire medication list, and entire immunization list (excludes protected mental health and HIV-related records).

☐ Any or all confidential mental health records protected under section 33.13 of the NY Mental Health Hygiene Law.

☐ HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV).

☐ The following specific information:

_____
_____
_____.

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" are a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose. Generally, for "transfer of care" or "medical treatment".

☐ Transfer of Care ☐ Medical Treatment ☐ Other

When will the authorization expire? The date or event that will cause this authorization to expire is noted below (generally dated one year from the day you completed this form).

☐ One Year ☐ Never ☐ Other

By signing this authorization, I authorize PRIMARY CARE OF WNY, LLP to use or disclose certain protected health information (PHI) described above. The information may be re-disclosed if the recipient described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Article 27-F of the NY Public Health Law governs HIV/AIDS related information. If you are authorizing the release of HIV-related information, you should know that the recipient is prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the 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 of disclosure of HIV-related information, you may contact the NY State Division of Human Rights at 212-870-8624 as an agency responsible to protect your rights.

If 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 one designated above is forbidden without your additional written authorization.

You have the right to refuse to sign this authorization. Your health care, the payment for your health care and your benefits will not be affected if you do not sign this form. You have the right to see and copy the information you described on this form in accordance with our policies and you have a right to receive a copy of this signed form.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke, please write to Dr. Cara Fininzio, Privacy Officer, PCWNY, LLP, 30 N. Union Road, Williamsville, NY 14221.

Signature: I have read this form and all of my questions about this have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Date: _____

Signature of Patient / Representative _____