AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Health Home, Children and Family Treatment & Support Services & Home & Community Based Services

CHILD'S NAME, (*LAST, FIRST, MI,):*		
DATE OF BIRTH:	SEX:	MEDICAID CIN #:

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, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Confidentiality law and regulations, 42 USC § 290dd-2, 42 CFR Part 2, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and/or DRUG ABUSE TREATMENT, 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 in Item 9(a), I specifically authorize release of such information only to the person(s) or organization(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. Any information released through this form regarding HIV-Related Information or Alcohol and/or Drug Abuse Treatment must be accompanied by a notice regarding the prohibition on redisclosure. 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 submitting a written notice of my decision to revoke consent to the Individual, Entity or 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, and that I do not have to sign this authorization. My refusal to sign will not affect the ability to obtain treatment separate from the ABBOTT HOUSE Heath Home, Children and Family Treatment & Support Services & Home & Community Based Services. However, my refusal to sign this authorization may affect health information available to determine eligibility for participation in the ABBOTT HOUSE in the above-mentioned program and services. My treatment, payment, enrollment in a health plan, or eligibility for other benefits will not be conditioned upon my authorization of this disclosure.

5. Information (except the types of information noted above in Item #2), disclosed under this authorization might be redisclosed by the recipient and this redisclosed information 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 INDIVIDUAL, ENTITY, OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and complete address of health provider or entity to release this information:

8. Names and complete address of person(s) or category of person, organization, facility or program to whom this information will be sent:

9(a). Specific (minimally necessary) information to be released:

□ Medical records from (insert date) _____ to (insert date) _____

□ Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referral, consults, and medical records received from other health care providers

□ Billing records

□ Insurance records

□ Other _____

Included: *(Indicate by Initialing)*
_____ Alcohol/Drug Abuse Treatment
_____ Mental Health Treatment Info.
_____ HIV-Related Information

9(b). Authorization to Discuss Health Information

□ By initialing _____ I authorize _____ to discuss my Health Information with
Initials — Name of Individual, Entity or Health Care Provider

_____
(Individual, Entity or Governmental Agency Name)

_____ _____
Signature — Date

10.Reason for release of information: