New York
Eye and Ear
Infirmary of
Mount
Sinai

The New York Eye and Ear Infirmary
310 East 14th Street
New York, NY 10003-4294
Tel: 212 979 4000
TTY: 212 979 4358

AUTHORIZATION FOR RELEASE OF INFORMATION

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. DO NOT SIGN A BLANK FORM.

SPECIFIC UNDERSTANDINGS

- By signing this authorization form, you authorize the use or disclosure of your protected health information. This information may be redisclosed if the recipients(s) described on this form is not required by law to protect the privacy of the information.
- If you are authorizing the release of HIV-related information, psychiatric, and/or alcohol or drug treatment information you should be aware that the recipient(s) is prohibited from redisclosing any of this specific information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use this specific information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.
- In addition to the Health and Insurance Portability and Accountability Act (HIPAA) OF 1996, the release of mental health information will be in accordance with the New York Mental Hygiene Law Section 33.13 and 33.16, and the release of alcohol and substance abuse information will be in accordance with 42 C.F.R. part 2, 45 C.F.R. Parts 160 and 164, and New York Confidentiality Laws.

YOUR RIGHTS ARE:

- You can refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.
- You can request to see and copy the information described on this authorization form in accordance with hospital policies.
- If you sign this authorization, you have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to:Privacy Officer / The New York Eye and Ear Infirmary, 310 East 14 Street, New York, New York 10003.

Patient Name: _____ **Med. Record #** _____
Last Name First Name

Address: _____
Street Apt #

_____
City State Zip

Telephone # _____ **SS#:** _____ **Date of Birth:** _____

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I hereby authorize the Medical Record Department of The New York Eye and Ear Infirmary to disclose copies of my health information to:

Name: _____

Address: _____

_____

Phone #: _____ FAX #: _____

Please release the specific information described below (complete one):

RECORDS CONCERNING TREATMENT FOR THE FOLLOWING MEDICAL CONDITION: _____

_____ DATE: _____

INCLUDE ONLY RECORDS FROM _____ TO _____ ABSTRACT _____

LAB _____ DATE _____

X-RAY _____ DATE _____

OTHER _____ DATE _____

The purpose for which the information will be used or disclosed _____

IF THE REQUESTED RECORD CONTAINS INFORMATION PERTAINING TO *PSYCHIATRIC, DRUG OR ALCOHOL TREATMENT* OR CONTAINS *HIV RELATED INFORMATION*, YOU MUST SPECIFICALLY CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING ONE OR BOTH OF THE FOLLOWING:

____ I understand that if my records contain information pertaining to psychiatric, drug or alcohol treatment, such information will be released pursuant to this consent form

____ I understand that if my records contain confidential HIV information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV

This authorization is valid for 1 year from the date of the patient's or patient representative's signature unless otherwise specified: _____
The date or event that will trigger the expiration

The hospital will be compensated for the cost of copying, mailing or other supplies we use to fulfill your request in accordance with NYS law.

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

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Print Name of Patient or Personal Representative **Description of Personal Representative's Authority**

I.D. Provided: _____ Accepted by: _____ Copy Provided: Yes No