UB|MD INTERNAL MEDICINE

HIPAA CONTACT AND AUTHORIZATION FOR RELEASE

1020 YOUNGS RD.
WILLIAMSVILLE, NY 14221
P: (716) 961-9900
F: (716) 961-9911

6105 TRANSIT RD.
E. AMHERST, NY 14051
P: (716) 348-3435
F: (716) 204-8229

300 LINWOOD AVE.
BUFFALO, NY 14209
P: (716) 961-9400
F: (716) 961-9402

6400 EDGEWOOD DR.
NIAGARA FALLS, NY 14304
P: (716) 898-4803
F: (716) 898-3928

462 GRIDER ST.
BUFFALO, NY 14215
NEPHROLOGY
P: (716) 898-4803
F: (716) 898-3928
BEHAVIORAL MED:
P: (716) 898-5671

Patient Name:	**Date of Birth:** / /

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the UBMD Internal Medicine, Inc. Notice of Privacy Practice. (also available at UBMDIM.COM)

Signature:	Date: / /

□ Patient refused and/or unable to sign
Staff member signature:

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY AND/OR FRIENDS

Name	Relationship	Primary Phone	Secondary Phone

AUTHORIZATION TO LEAVE MESSAGES

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you:

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	□ Yes □ No	□ Yes □ No
Voice Mail on Alternate Phone Number	- -	□ Yes □ No	□ Yes □ No
		May we send a message?	
Send through US Mail		□ Yes □ No	

RESTRICTIONS TO RELEASE OF INFORMATION

Please list any restrictions regarding information to be released:

SIGNATURE

Signature:	Date: / /

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

PLEASE SEND TO PREVIOUS PRACTICE

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

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 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, 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 on the box in Item 9(a), I specifically authorize release of such information to the person(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. 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 writing to the 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. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure 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 ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Please complete

Name and address of doctor (or other health professional) to release this information (e.g., your previous primary doctor)

8. Name and address of person(s) or category of person to whom this information will be sent: **UBMD INTERNAL MEDICINE**

Please complete

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Only if to Atty/Gov

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

Please complete

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:

Only if not patient

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Please Sign/Date

_____ 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.**