UBMD Internal Medicine & Pediatrics
Conventus
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UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____ Date of Birth: _____
Name (REQUIRED) (REQUIRED)

_____ Daytime Phone: _____
Address (REQUIRED)

_____

_____
(Social Security Number)

To Be Completed By UBMD IM Personnel Only:
Medical Record Number: _____
Date Sent: _____
Sender (Please Print): _____
Signature of Sender: _____

Authorize release of my protected health information (PHI):

FROM:
Name: _____
Address: _____
_____

TO:
Name: _____
Address: _____
_____

This authorization expires: _____ (Unless otherwise stated, authorization expires six (6) months from date of authorized signature).

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

I want the following information to be disclosed: (REQUIRED – Please specify):

_____
_____
_____

The purpose of this disclosure is: (REQUIRED – Please specify):

_____
_____

Please be aware that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected by this organization.

_____
Signature of Patient or Representative (REQUIRED if UBMD IM is sending medical records)

If representative, authority on which acting for the patient

Date: _____ PATIENT TO RECEIVE COPY OF THIS FORM
(REQUIRED)

REQUIRED fields must be completed for Release of Protected Health Information
UBMD Internal Medicine will not condition the provision of treatment on the provision of this authorization.

By signing this form, you authorize the use or disclosure of your protected health information as described above. This information may be disclosed if the recipient(s) 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 regulation.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) 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 a 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 or disclosure of HIV-related information, you may contact the NYS Division of Human Rights at (212) 870-8624. This agency is responsible for protecting your rights.

You have the right to refuse to sign this authorization. UBMD Internal Medicine may not condition treatment or payment on the provision of this authorization except under the following circumstances:

- UBMD Internal Medicine may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, or
- UBMD Internal Medicine may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

Under certain circumstances UBMD Internal Medicine may combine authorizations as indicated below:

- An authorization for the use or disclosure of protected information for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of protected health information for such research or a consent to participate in such research; REFUSED _____ (Patient initials required)
- An authorization, for a use or disclosure for psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes;
- An authorization, other than for a use or disclosure of psychotherapy notes, may be combined with any other such authorization except when UBMD Internal Medicine has conditioned the provision of treatment or payment as noted above.

You have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you have the right to revoke it at any time, except to the extent that UBMD Internal Medicine has already taken action based upon your authorization. To revoke this authorization, please contact the office manager or other authorized person at UBMD Internal Medicine to obtain a Request to Revoke Authorization form.

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

Signature	Date
Patient Name or Personal Representative (please print)	Description of Personal Representative's Authority
Address of Representative	Telephone Number