The Saratoga Hospital

211 Church Street, Saratoga Springs, NY 12866

Authorization to Disclose Protected Health Information

Patient Name (First and Last): _____

Date of Birth: _____ Phone Number: _____

Address (Street, City, State, & Zip Code): _____

I hereby authorize Saratoga Hospital and its affiliates to disclose or permit use of health information, as described below, concerning the above named individual. I understand that federal and state law offer special protection for information relating to **sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or the human immunodeficiency virus (HIV). Similar protections exist for information about behavioral or mental health services, and treatment for alcohol and drug abuse.** I understand that, if the health information covered by this authorization contains such information, I am waiving those protections in this instance by voluntarily authorizing use or disclosure of the health information.

The undersigned hereby authorizes Saratoga Hospital to disclose my individual health information as described below. **(Check one)**

☐ **Copy of record** ☐ **Review Record**

Date(s) of visit: _____ Choose the type and amount of information to be used or disclosed as follows:

☐ Summary	☐ Laboratory Results*	☐ Radiology Reports	☐ Radiology Films
☐ Operative Report	☐ Discharge Summary	☐ History and Physical	☐ Emergency Record
☐ Mental Health	☐ Other: _____		

DISCLOSE TO: _____ **REASON OR PURPOSE:** _____

Check One:

☐ By Mail: **ADDRESS:** _____

☐ Email**:** **E-MAIL ADDRESS:** _____

☐ By Fax: **FAX NUMBER:** _____

☐ Other: **EXPLAIN:** _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on _____. **If I fail to specify an expiration date, event or condition, the authorization will expire in 90 days.** I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy rules or New York law. I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. **I understand the fee for copies of my medical record is $0.75 cents per page. This fee will be waived if the records are being sent to another physician or for continuing treatment.**

If I am authorizing the release of HIV-related information, recipient is prohibited from re-disclosing 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.

_____ _____

Signature of Patient or Legal Representative — Date / Time

_____ _____

If Signed by Legal Representative, Relationship to Patient — Date / Time

_____ _____

Signature of Witness — Date / Time

********** **SARATOGA HOSPITAL USE ONLY**********

_____ _____

Signature of Staff Disclosing Information / Title — Date / Time Completed

☐ Photo ID verified - Initials: _____ Medical Record Number: _____

Please Note: If these records are covered under Federal confidentiality rules (42 CFR Part 2), this rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.