GLOW
PRIMARY CARE
3027 Jericho Tpke
East Northport, NY 11731
Tel: 516-665-1476
Fax: 516-620-3773

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name:** _____ **Social Security Number:** _____

**Patient Address:** _____ **Date of Birth:** _____

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 Article 27-F of the New York State Public Health Law, 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 10(b). 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 10(b), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. In the event that a determination is required for disability benefits, I authorize **Glow Primary Care** to release my medical and/or mental health treatment information, which may include confidential HIV related information and/or alcohol or drug treatment records to the **Social Security Administration (SSA)** for its review of my eligibility for federal disability benefits.
3. 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) 961-8650** or the **New York City Commission of Human Rights at (212) 306-7450**. These agencies are responsible for protecting my rights.

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4. I understand that signing this authorization is voluntary. My treatment, payment to treatment providers, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. I understand that I may revoke this authorization at any time, except to the extent that **Glow Primary Care** and any previously authorized recipients have already acted upon it. I may revoke this authorization by writing to Glow Primary Care at the address specified below.
6. Authorized recipients of my medical information may, in certain instances, have the right to **redisclose** my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.
7. This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than the designated recipient as specified in item 10(b).

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**AUTHORIZATION TO DISCUSS HEALTH INFORMATION**

8. **Name and address of health provider or entity to release this information:**
   **Glow Primary Care located at:**
   **3027 Jericho Tpke East Northport, NY 11731**
   **Tel: 516-665-1476 - Fax: 516-620-3773**

9. **Name and address of agency to whom this information will be sent:**

   _____

   _____

   _____

10(a). **Specific information to be released:**
Medical records for the entire year prior to the signature date below. Include (Indicate by Initialing):

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

10(b). By initialing here _____, I authorize
_____ (Initials)
(Name of individual health care provider) to discuss my health information with the designated agency in Item 9.

11. **Reason for release of information:**
☐ At request of patient
☐ Other (please specify): _____

12. **Date or event on which this authorization will expire:**
☐ One year from the date of signature
☐ Other (please specify): _____

13. **If not the patient, name of person signing form:**
_____

14. **Authority to sign on behalf of patient:**
_____

_____

All items on this form have been completed and my questions about this form have been answered. I have been provided with a copy of this form.

**Signature of Patient or Authorized Representative by Law:**

Full Name: _____ Signature: _____

**Date:** _____