
**Instructions for Completing the Authorization for
Release of Health Information Pursuant to HIPAA Form**

These instructions will help you to complete the following form. It is important that you read each line of the form carefully and that you make sure to fill in each box correctly.

- **On the top** – Enter your (the patient) information where the boxes ask for “Patient Name”, “Date of Birth”, “Social Security Number”, and “Patient Address”
- **Lines 1-6** – Read carefully and understand
- **Line 7** – Name and address of the health provider/office to release this information. If requesting records from Be Well, please print “Be Well Primary Health Care Center – 3007 Farragut Rd, Brooklyn, NY 11210”
- **Line 8** – Name and address of person/agency to whom this information will be sent. You can write “self” if the records are going directly to you, if they need to be sent to another agency such as a law firm, write in their information.
- **Line 9(a)** – Specific Information to be released: Tell us what information you allow us to release.
 - First Box - If you want us to release records for a specific time period, check the first box and write in the beginning and end dates
 - Second Box - If you want us to release the entire medical record, check the second box (Entire Medical Record)
 - Other Box - If you want specific records (for example, records from a specific doctor or relating to a specific condition) check the “Other” Box and clearly describe what information you want us to release.

IMPORTANT: If you want us to give Alcohol or Drug Treatment, Mental Health Information, or HIV-Related Information that may be in your records, enter your initials next to each type of information listed in Item 9(a) that you want us to share. If you do not want us to release this type of information, leave the lines blank.

- **Line 9(b)** – Authorization to Discuss Health Information (*optional*)
 - If you want to allow us to discuss your health information with someone else, check the box next to the (b) and enter your initials on the first line.
 - Print or type your doctor’s name on the line that says “Name of individual health care provider.”
 - Print or type the name of the person, attorney, law firm, agency or group that we can talk to about your information.
- **Line 10** – Reason for release of information: Tell us why you want us to give your information to someone else. As the patient, you just have to check the first box in Item 10 “At request of individual”. If you want us to give your information for any other reason, check the “Other” box and print or type the reason.
- **Line 11** – Date or event on which this authorization will end: Put the date when we should stop giving information (for example, “12/31/2025” or “at the end of litigation”).
- **Lines 12 and 13** – If someone other than the patient signs the form (such as a legal guardian, parent, Power of Attorney, or other authorized representative), they must print or type their own name on Line 12 and state their relationship/authority on Line 13.
- **Bottom** – Sign name and date.

**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).**

7. Name and address of health provider or entity to release this information:

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

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**

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)

10. Reason for release of information:

- ☐ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:

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.

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.**