CP Rochester
Authorization for the Use or Disclosure of Protected Health Information - HIPAA

As required by the Health Insurance Portability and Accountability Act of 1996, our agency may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to the Privacy Officer.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use and disclosure of the following health information pertaining to:
Individual's Name (print) _____ DOB _____ ☐ Male ☐ Female

Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including histories, 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**

Reason for release of information:
- ☐ At request of individual
- ☐ To establish eligibility
- ☐ To facilitate program planning
- ☐ Other: _____

I authorize the following persons/provider to *make* these disclosures of my health information: **CP Rochester;** _____

I authorize the following persons/ provider to *receive* these disclosures of my health information: **CP Rochester;** _____

Signature of the patient or (if applicable) Guardian/Legal Representative: _____Date: _____

If not the patient, print name of person signing form: _____ Relationship: _____

Witness: _____Date: _____

By my signature:

- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Privacy Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted on reliance on this authorization.
- I understand that this authorization will remain in effect until revoked by an authorized individual or the expiration of services.
- I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant of this authorization.

REVOCATION SECTION

I hereby revoke this authorization effective: _____

Individual Name: _____ DOB: _____

Signature of the patient or (if applicable) Guardian/Legal Representative: _____Date: _____

If not the patient, print name of person signing form: _____ Relationship: _____

Witness: _____Date: _____

Revised: 8/2017