County of Greene

Authorization for Use and Disclosure of Protected Health Information

THIS FORM IMPLEMENTS THE REQUIREMENTS OF THE STANDARDS FOR PRIVACY OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (THE PRIVACY RULE) ESTABLISHED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). EXCEPT AS OTHERWISE PERMITTED OR REQUIRED BY THE PRIVACY RULE, A HEALTH CARE PROVIDER MAY NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT AN AUTHORIZATION THAT COMPLIES WITH THE REQUIREMENTS OF 45 C.F.R. SECTION 164.508. THE HEALTH CARE PROVIDER MUST GIVE A COPY OF THIS COMPLETED FORM TO THE PATIENT.

Patient'sName_____Date of Birth _____ SSN: _____

Address_____

I hereby authorize the use and disclosure of protected health information for treatment rendered during the time period:
From_____ through _____.

The information described below may be disclosed by: (NAME OF PERSON(S), ENTITY OR CLASS OF PERSONS THAT WILL DISCLOSE INFORMATION).
_____

The information described below may be disclosed to: Greene County Youth Bureau

The Specific Type(s) of information authorized are as follows: **(Circle ALL appropriate types)**

INPATIENT HOSPITAL OUTPATIENT HOSPITAL PHYSICIAN/SUPPLIER CLINICAL LABORATORY

HOME HEALTH AGENCY SKILLED NURSING FACILITY OTHER (SPECIFY) _____ _____

The information that may be used or disclosed includes: **(Circle ALL appropriate types)**

INTERVIEW OF ATTENDING PHYSICIAN(S) ALL TREATMENT RECORDS HIV RELATED TREATMENT RECORDS

BEHAVIORAL HEALTH/PSYCHIATRIC TREATMENT RECORDS DRUG AND ALCOHOL TREATMENT RECORDS

(Disclosure of HIV related information is controlled by NY State Public Health Law. Disclosure of alcohol and drug abuse information is controlled by 42 C.F.R. parts 2. Re-disclosure of such in formation is forbidden without your additional written authorization unless permitted under state or federal law.)

The purpose of disclosure is: **(Circle one)**

REQUEST OF THE INDIVIDUAL WHO IS THE SUBJECT OF THE RECORDS OR HIS/HER PERSONAL REPRESENTATIVE

OTHER **(Describe)** _____

THIS AUTHORIZATION MAY BE REVOKED BY WRITTEN REQUEST TO THE MEDICAL SERVICE PROVIDER'S PRIVACY OFFICER. INFORMATION DISCLOSED PRIOR TO RECEIPT OF THE REVOCATION MAY NOT BE RETRIEVED. IF ACTION WAS TAKEN IN RELIANCE ON THE AUTHORIZATION, THE PERSON WHO RELIED ON THE AUTHORIZATION MAY CONTINUE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AS NEEDED TO COMPLETE WORK THAT BEGAN BECAUSE THE AUTHORIZATION WAS GIVEN. TO REVOKE THIS AUTHORIZATION PLEASE WRITE TO:

_____
(Name of Health Care Provider)

_____
(Address)

_____
(City, State, Zip)

This authorization expires on _____ or upon the following event: _____

_____
(SIGNATURE)

_____
(Print name of patient or personal representative)

_____
(Date)

_____
(Description of personal representative's .

authority)

YOU HAVE A RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. THE MEDICAL SERVICE PROVIDER MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS ON WHETHER YOU SIGN THIS AUTHORIZATION. IT IS UNDERSTOOD THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE RE-DISCLOSED BY THE RECIPIENT. INFORMATION DISCLOSED MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY RULES.

YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AFTER YOU HAVE SIGNED IT.