Maimonides
Medical Center
Brooklyn, NY 11219

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION TO / FROM MAIMONIDES MEDICAL CENTER AND / OR MAIMONIDES FACULTY PRACTICE

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your authorization before we may use or disclose your protected health information from the medical record maintained by the Medical Center for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

♦ **I hereby authorize (check one):** ☐ Maimonides Medical Center (or any of its employees, staff or agents)

☐ _____

to release protected health information from the medical record(s) of: _____

ADDRESS: _____ PHONE NO.: _____

MEDICAL RECORD NUMBER: _____ DATE of BIRTH: _____/_____/_____

♦ **To the individual or organization listed below (check one):**

☐ _____

_____

_____

_____

☐ Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, NY 11219 ATT: _____
718-283-6000

☐ Maimonides Cancer Center
6300 Eighth Avenue
Brooklyn, NY 11220 ATT: _____
718 765-2500

♦ **For the purpose of (check one) :**

☐ CONTINUING MEDICAL TREATMENT
☐ PERSONAL REASONS (i.e. "at the request of the individual")
☐ LITIGATION / ATTORNEY REVIEW
☐ OTHER (Specify) _____

☐ INSURANCE: Insurance Company Name: _____ Claim File #: _____

♦ **I request the release of (check one) :**

☐ Entire record
☐ The following portions of the record (specify documents and / or dates of treatment):
- ☐ Request for an electronic copy of health information.
- ☐ Request for an electronic copy of discharge instructions.
- ☐ Entire record only for the Dates of Treatment as follows: _____
- ☐ Emergency Room Record / Date(s): _____
- ☐ Outpatient Record(s) / Date(s): _____
- ☐ Operative Report(s) / Date(s): _____ ☐ Discharge Summary / Date(s): _____
- ☐ Laboratory Reports / Date(s): _____ ☐ Pathology Reports / Date(s): _____
- ☐ Radiology Reports / Date(s): _____ ☐ EKG / Date(s): _____
- ☐ Echocardiogram / Date(s): _____ ☐ Cardiac Cath Report / Date(s): _____

☐ The following HIV-related information _____
(which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV).

☐ Billing Records (specify): _____

☐ Other (specify): _____

♦ **This authorization will expire six (6) months from the date hereof, unless there is a date or event described below:**

☐ _____

_____

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above.

You understand that once the information is disclosed pursuant to this authorization, the information may be subject to redisclosure by the recipient and may not be protected by federal privacy regulations (if the recipient is not required by law to protect the privacy of the information).

You understand that the type of information to be disclosed, if applicable may include: DIAGNOSIS, PROGNOSIS, TREATMENT FOR ABUSE, TREATMENT FOR PHYSICAL AND/OR MENTAL ILLNESS, TREATMENT FOR ALCOHOL/SUBSTANCE ABUSE, TREATMENT FOR SEX-RELATED CONDITIONS, AND ALL INFORMATION CONSIDERED TO BE PART OF THE MEDICAL RECORDS FILE, INCLUDING GENETIC INFORMATION, IF ANY. Additional release forms may be required if the patient record contains certain types of specially protected information.

If your are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have the right to refuse to sign this authorization and your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form; provided, however, that if Maimonides is providing health care solely for the purpose of creating protected health information that will be disclosed to a third party, it may require you to sign this authorization form before providing health care.

You have a right to see and request a copy of the information described on this authorization form in accordance with hospital policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon this authorization. To revoke this authorization, please write to Director, Health Information Services, Maimonides Medical Center, 4802 Tenth Avenue, Brooklyn, New York 11219.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and that I agree to all of the above.

Please ... SIGN HERE

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____/_____/_____ Description of Personal Representative's Authority

Date

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address: Telephone:

_____ (daytime) _____(evening)

Email address (optional):

* If Maimonides Medical Center is seeking authorization to use or disclose protected health information that it maintains in its own records, please be advised that the hospital will not receive compensation for the use or disclosure unless otherwise specified.

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL