Samuel S. Badalian MD PC

Patient Authorization For Release of Protected Health Information

In accordance with federal and state law, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. Please read the information below carefully before signing this form. All fields must be completed. Please be aware that fees may apply to this request for the costs of copying, shipping/postage, and/or electronic media storage device provided.

Patient Name:_____Date of Birth_____

Patient Address_____ Phone _____

Request is for the information to be released on ☐ Paper or ❑ Electronic Media.

I, or my personal representative, hereby authorize Samuel S. Badalian MD PC to use or disclose protected health information regarding my care and treatment. I understand that:

1. Information relating to **alcohol/drug abuse, mental health treatment, genetic testing, and/or confidential hiv-related information** will not be disclosed unless I specifically authorize such disclosure by placing my initials in the appropriate space(s) in Item 8(b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of **HIV-related information**, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a 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 use or disclosure of HIV-related information, I may contact the New York State Division of Human Rights.

3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent Samuel S. Badalian MD PC has already relied upon this authorization.

4. Signing this authorization is voluntary. Samuel S. Badalian MD PC may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information as requested above (one provider per form):

Name: _____

Address: _____

6. Purpose for release of information:

❑At my request ☐ Continuity of Care ❑Other: _____

7. Person(s) receiving this information:

☐ Send to Name: _____

Address: _____

❑ I will pick it up ☐ My personal representative _____
will pick it up. Identification will be required for pick-up.

8. Description of information being released:

a) Specific date(s) of service (required; list all dates):_____

_____

I would like (choose one):

❑ An abstract (pertinent information related to the above listed date(s)

☐ My entire Medical Record

❑ Other: _____

☐ Include information relating to (initial beside each applicable category):
Alcohol/Drug Treatment _____
Mental Health Treatment _____
Genetic Testing Information _____
HIV-related Information _____ (If yes, complete an official NYSDOH HIV release form)

9. Date or event on which this authorization will end:

☐One-Time Request ❑Specific Event or Date : _____

10. Signature: By signing below I acknowledge that I have read and agree with all of the above, and I acknowledge that any fees must be paid prior to the release of information.

Signature: _____ Date: _____/_____/_____

Print name of patient or personal representative signing above :_____

Include personal representative's authority (supporting documentation required):

❑ Parent ☐ Guardian ❑ Health Care Agent ☐Administrator/Executor

❑Other: _____

Office Use:
Received: ____/_____/_____ Completed: ____/_____/_____

Initials of Employee Completing this Task: _____

Office Staff: A copy of this form must be provided to the patient upon signing. Please scan the completed form into the patient's chart.