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# How to Complete Your New York HIPAA Authorization

Authorization for Release of Health Information — HIPAA (45 C.F.R. § 164.508), New York

**INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR FORM.**

**About this form.** This form lets doctors, hospitals and insurers **share your health information** with a person you choose, such as a family member, your health care agent or your financial agent. It does **not** let anyone make medical decisions; for that, use a New York Health Care Proxy.

1. **Patient and providers (Sections 1 and 2)**
   Enter your information. Name a specific provider, or check the box to cover all providers.

2. **Who receives it (Section 3)**
   Name the person or organization who may receive your information.

3. **What is released (Section 4)**
   Check your full record or describe what is limited. Mental health, drug and alcohol treatment, and genetic records are released only if you check them. **HIV information needs a separate New York State-approved form.**

4. **Purpose and expiration (Sections 5 and 6)**
   State the purpose and an end date or event. If you leave it blank, the form expires in one year.

5. **Sign and notarize**
   Do **not** sign ahead of time. Notarizing helps providers confirm your identity, especially for out-of-state records or records sent to a family member or agent. Bring a current government-issued photo ID.

## After It's Signed

- Send a copy to each provider or plan named in Section 2, and give a copy to the person you named in Section 3.
- Many providers accept this form; some require their own. Ask the provider if you are unsure.
- To cancel it, send a written revocation to each provider. Keep a copy for your records.

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**Have questions about this form?** To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**, 2315 Capitol Avenue, Sacramento, CA 95816. **Attorneys licensed in New York.** Main headquarters in Sacramento, California.

This form is provided as a free convenience. First Choice Mobile Notary & Apostille is not a law firm, and a notary public cannot give legal advice or help you decide what to write on this form. These instructions are general information only and are not legal advice. If you have questions about your situation, consult a licensed New York attorney.

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# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

HIPAA Authorization — 45 C.F.R. § 164.508 (New York)

## 1. Patient

Patient name: _____ Date of birth: _____

Address: _____

Telephone: _____ Email (optional): _____

## 2. Who May Release the Information

Provider / health plan / facility: _____

☐ Any doctor, hospital, clinic, pharmacy, laboratory, insurer or other HIPAA-covered entity that has treated me or holds my health information.

## 3. Who May Receive the Information

Name: _____ Relationship: _____

Address / phone: _____

Additional recipient (optional): _____

## 4. Information to Be Released

☐ My entire medical record, including medical history, diagnoses, test results, prescriptions, billing and insurance records.

☐ Only the following information or dates of service:

_____

**Specially protected information.** The following will be released only if I check the box:

☐ Mental health information (this does not include psychotherapy notes, which require a separate authorization).

☐ Alcohol or drug (substance use disorder) treatment records.

☐ Genetic testing information.

HIV/AIDS-related information may be released in New York only on a form approved by the New York State Department of Health (such as Form DOH-2557 or OCA Form 960). This form does not authorize release of HIV-related information.

## 5. Purpose

☐ At my request (personal use, caregiving, family or agent access).

☐ Other purpose:

_____

## 6. Expiration

This authorization expires on the date or event below. If none is entered, it expires one year from the date signed.

Expiration date or event: _____



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## 7. My Rights

**(a)** I may revoke this authorization at any time by sending a written revocation to the provider or plan named in Section 2, except to the extent action has already been taken in reliance on it.

**(b)** My treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization, except as permitted by law.

**(c)** Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law. Substance use disorder records and certain New York-protected information remain subject to restrictions on redisclosure.

**(d)** I am entitled to a copy of this authorization.

## 8. Signature

_____ _____

Signature of patient or personal representative Date

Printed name: _____

If signed by a personal representative, describe your authority (for example, health care agent, guardian, parent of a minor, executor), and attach a copy of the document:

_____

### Acknowledgment Before Notary Public

### ACKNOWLEDGMENT OF SIGNER (Real Property Law § 309-a)

State of New York )
) ss.:
County of _____ )

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

Signature and office of individual taking acknowledgment

Notary Public, State of New York; Qualified in _____ County

Registration No. _____; Commission Expires _____

(Notary stamp)



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