***Digicomp Lockup Info***

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**Advanced OB-GYN, PLLC**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS**

## An additional authorization (NYS DOH-5032) is required for disclosures when your medical records contain information relating to Alcohol and/or Drug Treatment, Mental Health Treatment, or Confidential HIV/AIDS information including but not limited to test results and the fact that the test was taken.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City State Zip Code

**Patient Date of Birth: \_\_\_\_\_\_\_\_ \_\_/\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize:**

* **Advanced OB-GYN, PLLC**
* **Other Healthcare Provider (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(include address and phone/fax numbers)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To release:**

* **Protected Health Information including** **Sensitive Protected Health Information (HIV/AIDS-related information, Substance Abuse Treatment, or Mental Health Treatment information.) *REQUIRES COMPLETION OF ADDITIONAL AUTHORIZATION FORM NYS DOH-5032 – ATTACHED.***

**Pertaining to my (check one or more as applicable):**

* Outpatient/ Office Visit(s) **(date range)** \_\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_
* Hospital admission **(discharge date)** /
* Emergency Department visit **(date)** / /
* Ambulatory/Outpatient admission **(date)**\_\_\_/\_\_\_\_/\_\_
* All medical records related to Diagnostic Testing/Interventional Radiology Services

Date(s) of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* All medical records related to a specific illness/injury

Illness/Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize disclosure of the following information from my medical record (check, where applicable list type and date):**

* PAP Result/Report \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Lab Test Results/ Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* History & Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Clinical Documentation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Radiology & Imaging Reports (Please Circle): U/S CT MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Endometrial Biopsy Results/ Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Pathology Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Operative Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Discharge Summary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Billing Records\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Image (of Patient and/or Patient’s Child) and other Patient-Identifiable Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

* Entire copy of the medical record

**From my medical records to:**

* Advanced OB-GYN, PLLC, Physicians Office Building South, 4850 Broad Road, Suite 2C, Syracuse, NY 13215 Office: 315.492.5915 Fax: 315-492-5741

**OR**

* Name of organization or person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt. # \_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (Area Code and Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (Area Code and Number):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The purpose(s) for which disclosure is authorized (check where applicable):**

* **Medical Care**
* **Transfer of Care**
* **Insurance Coverage**
* **Personal**
* **Advanced OB-GYN, PLLC Subsidized Marketing Communications**
* **For Use in Advanced OB-GYN, PLLC Advertising and/or on Website/Social Media Platforms**
* **Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that:**

1. Advanced OB-GYN, PLLC will not condition treatment, payment for services, or eligibility for services on whether I provide Authorization for any requested disclosure by Advanced OB-GYN, PLLC.

2. **I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee (up to $ .75/page plus postage) as described in our Notice of Privacy Practices.**

1. This Authorization is voluntary and that I have the right to refuse to sign it.
2. PHI r eleased pursuant to this authorization may include records generated by another healthcare provider or facility which are now part of my Advanced OB-GYN, PLLC medical record.
3. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practices; however such revocation would not affect any action taken by Advanced OB-GYN, PLLC in reliance on this Authorization before receipt of my written revocation.
4. **This Authorization will expire on \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ (fill in date if less than 1 year) or 1 year after being signed.**
5. The information disclosed pursuant to this Authorization, ***except*** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
6. My medical records may contain genetic testing information including test results.
7. I have a right to receive a copy of this authorization.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of patient/personal representative (e.g., legal guardian) Date

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name. If personal representative, indicate relationship to patient.

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court)

**NEW YORK STATE DEPARTMENT OF HEALTH** **Authorization for Release of Health Information (Including Alcohol/Drug Treatment  
 and Mental Health Information) and Confidential HIV/AIDS-Related Information**

***Digicomp Lockup Info***

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Page: 2 Plate: Black Stub: Top

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Right: 1.612"



|  |  |  |
| --- | --- | --- |
| Patient Name | Date of Birth | Patient Identification Number |
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8, I specifically authorize release of such information to the person(s) indicated in item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. Any unauthorized further disclosure of HIV/AIDS-related information in violation of state law may result in a fine or jail sentence or both. For alcohol and substance abuse re-disclosure, Federal Confidentiality rules (42 CFR part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Top of Form

|  |  |  |  |
| --- | --- | --- | --- |
| 5. Name and Address of Provider or Entity to Release this Information: | | | |
| 6. Name and Address of Person(s) to Whom this Information Will Be Disclosed: | | | |
| 7. Purpose for Release of Information: | | | |
| **8. Unless previously revoked by me, the specific information below may be disclosed from:**  INSERT START DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_ until INSERT EXPIRATION DATE OR EVENT\_\_\_\_\_\_\_\_\_\_\_\_\_  All health information (written and oral), except: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **For the following to be included, indicate the specific information to be disclosed and initial.**  Records from alcohol/drug treatment programs | **Information to be Disclosed** | | **Initials** |
| Clinical records from mental health programs\* |  | |  |
| HIV/AIDS-related information |  | |  |
| 9. If not the patient, name of person signing form: | | 10. Authority to sign on behalf of patient: | |

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
SIGNATURE OF PATIENT OR REPRSENTATIVE AUTHORIZED BY LAW DATE

**Witness/Statement Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient’s authorized representative.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
STAFF PERSON’S NAME & TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

**\* NOTE:** Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)