Jamaica Hospital Medical Center

8900 Van Wyck Expressway, Jamaica, New York 11418

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		
Phone Number	Email Address of Recipient:	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV*RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the 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 release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE.**

7. Name and address of health provider or entity to release this information:

Jamaica Hospital Medical Center, 8900 Van Wyck Expressway, Jamaica, New York 11418

8. Name and address of person(s) or category or person to whom this information will be sent:

9(a) Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date)_____
- ☐ Entire medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Please indicate how you want to receive records. Choose one only:

- ☐ Paper
- ☐ CD
- ☐ MediSys MyChart Patient Portal (electronic)
- ☐ E-mail Encrypted: _____
  Print E-Mail Address

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

10. Reason for release of information	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other	**One year from today or the date or event I have listed :**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

_____ __ Date: _____

Signature of patient or representative authorized by law

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Jamaica Hospital Medical Center
MediSys Health Network Locations: Facilities

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

I would also like for my medical records to be released from the following site(s). (Indicate by initialing)

SITE	MAILING ADDRESS	TREATMENT DATE	INITIALS
Jamaica Hospital Nursing Home	89-40 135th Street Jamaica, New York 11418		
East New York	3080 Atlantic Avenue Brooklyn, New York 11208		
Hollis	188-03 Jamaica Avenue Hollis, New York 11423		
Hollis Tudors	200-16 Hollis Avenue Hollis, New York 11423		
Howard Beach	156-10 Cross Bay Blvd. Howard Beach, New York 11414		
Jamaica (formerly Sutphin)	149-18 Jamaica Avenue Jamaica, New York 11435		
Ozone Park	91-20 Atlantic Avenue Ozone Park, New York 11416		
Richmond Hill – Family Practice	133-03 Jamaica Avenue Jamaica, New York 11418		
Senior Health Center	91-20 Atlantic Avenue Ozone Park, New York 11416		
St. Albans	111-20 Merrick Blvd. St. Albans, New York 11433		
Richmond Hill - Woman's Health Center	133-03 Jamaica Avenue Richmond Hill, New York 11418		
Advanced Center for Psychotherapy-Jamaica Estates	178-10 Wexford Terrace Queens, New York 11375		
Advanced Center for Psychotherapy-Forest Hills	103-26 68th Road Jamaica, New York 11375		
Jamaica Hospital Medical Center Mental Health Clinic	90-09 Van Wyck Expressway Jamaica, New York 11418		

I translated for this patient on (date) _____ _____ with their permission so the authorization could be completed properly and I answered all questions asked of me.

Date: _____ Print Name: _____

Signature: _____ Title: _____