SJH CARDIAC CATHETERIZATION ASSOCIATES, P.C. (SJHCA)
PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Social Security Number: _____ /DOB: _____
Patient Address: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, or my authorized representative, hereby authorize the use or disclosure of my individually identifiable health information as described below.

In accordance with New York State Law and the Privacy Rule of 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 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 redisclosing 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) 480-2493or the New York City Commission Of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I understand that I may revoke this authorization at any time by notifying SJHCA in writing, but if I do revoke it, the revocation will not have any effect on any actions SJHCA took before it received the revocation.

4. I understand that 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 redisclosed by the recipient (except as noted above in Item 2), and this redisclosure 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 OTHER THAN THE PERSON(S) SPECIFIED IN ITEM 9(B).

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

_____

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

_____

9a. Specific description of information (including date(s)) to be released:

_____

_____

[] Other: _____Alcohol/Drug Treatment; _____Mental Health Information; _____HIV-related Information
initials **initials** **initials**

9b. Authorization to Discuss Health Information:

By initiating here _____ I authorize SJH CARDIOLOGY ASSOCIATES to discuss my health information with
initials

_____.
Name of entity or person(s)

10. Reason for release of information:

_____

11. Date on which this authorization will expire:

_____/_____/_____

12. If not the patient, name of person signing form:

_____

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 this form. I also agree to pay $.75 cents per page for these records where applicable.

_____ _____

Signature of patient or representative authorized by law Date

***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.**