Family Services
communities without limits

GENERAL
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT'S NAME: _____ **LOCATION**: _____ **DOB:** ___ /___ /___

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, as well as MENTAL HEALTH TREATMENT**. Disclosure of **CONFIDENTIAL HIV RELATED INFORMATION** requires an additional authorization.
2. By authorizing the release of 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. If I experience discrimination because of the release or disclosure of information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is 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 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 FSI, INC. TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY IDENTIFIED BELOW.**
7. **PLEASE INIITAL NEXT TO THE INDIVIDUAL OR ENTITY YOU WISH FSI, INC. TO SHARE AND DISCUSS YOUR HEALTH INFORMATION WITH.**

AGENCY/PERSON(S) NAME:_____ **Fax/Email:** _____

Address: _____ **Phone:** _____

8. Specific information to be released:

☐ Psychiatric Assessment ☐ Psychosocial Assessment ☐ Progress Notes ☐ Medication History ☐ Treatment Plans
☐ Attendance ☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record including progress notes, assessments, treatment plans, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: Most recent labs/ bloodwork, current medications, problem list, annual physical examination result, EKG results (if applicable)

9. Reason for release of information:
☐ At request of individual ☐ Other: _____

10. My authorization is subject to revocation at any time (except to the extent that action has already been taken) and EXPIRES:

☐ UPON MY REVOCATION OR SIX MONTHS FOLLOWING TERMINATION OF TREATMENT, OR

☐ ON THIS EVENT OR DATE: _____

Unless an expiration date or event is specified, this authorization is valid for 1 year from the date which it was signed.

Date: _____ **Patient Signature**: _____

OR

Patient's representative who is empowered to act on his/her behalf by reason of _____

Date: _____ Print Name: _____ Signature: _____

I have been offered/received a copy of this authorization: _____ (Please Initial)

☐ **REVOKED** **Effective Date:** _____ **Signature:** _____

CH REVISED 04/01/2019
CH REVISED 10/30/2019
BM REVISED 04/08/2026