Eastern Niagara Hospital

☐ **Lockport**
521 East Ave, Lockport, NY 14094

☐ **Newfane**
2600 William St, Newfane, NY 14108

☐ **Imaging Center**
5875 S. Transit Rd, Lockport, NY 14094

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released by **EASTERN NIAGARA HOSPITAL** as specified 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 in relation to **ALCOHOL and DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, (except psychotherapy notes), and **CONFIDENTIAL HIV RELATED INFORMATION** if I place my initials on the appropriate line in item 6. In the event the health information described below includes any of these types of information, and I initial the line in the box in Item 6, then I specifically authorize release of such information to the person(s) indicated in Item 5.
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.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. 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.

5. Name and address of entity/person(s) to whom this information will be sent:

6. Specific information to be released:

__ Medical Record from (insert date) _____to (insert date) _____

__ Entire Medical Record, including patient history, progress notes, discharge summary, test results, radiology reports and consults.

__ Radiology Reports: _____
__ Emergency Room Record: _____
__ Lab Reports:_____
__ Billing records: _____
__ Other: _____

Include: (indicate by initialing)

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

__ Discharge plan, notification of discharge or transfer, post-discharge care information and instructions

7. Reason for release of information: ___ At request of individual ___ Other: _____	8. Date on which this authorization will expire:
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 and my questions about this form have been answered.

_____ _____
Signature of patient or representative authorized by law Date

HIPAAREL