Weill Cornell Medicine

Authorization To Use or Disclose Protected Health Information (PHI)

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____
(if available)

I authorize the release of the following health information (check below):

- ☐ Entire medical record
- ☐ Diagnostic Tests — Date(s): _____
- ☐ Doctor's Notes (from Dr._____) — Date(s): _____
- ☐ Lab Results — Date(s): _____
- ☐ Pathology Reports_____Specimens _____ — Date(s): _____
- ☐ Radiology Reports_____Images _____ — Date(s): _____
- ☐ Include Alcohol/Drug Treatment information (initial here) _____
- ☐ Include Mental Health information (initial here) _____
- ☐ Include HIV-Related information (initial here) _____
- ☐ All of the above with the exception of: _____
- ☐ Other:_____

Who will <u>release/disclose</u> information:

Provider: _____

Address: _____

City, State, Zip: _____

Who will <u>receive</u> information:

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____ Fax:_____

Reason for Disclosure: _____

This authorization expires: ☐ specific time frame_____, ☐ when record is received, ☐ other (explain)

_____

I understand that:

- By signing this form, I am authorizing the use/disclosure of protected health information as indicated above.
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time by completing a "Request to Revoke an Authorization" form, which is available at Weill Cornell Medicine's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. Weill Cornell Medicine shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements.
- I may request a copy of this signed form.
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment.

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.