CWRC
CENTER FOR WOMEN'S REPRODUCTIVE CARE AT COLUMBIA UNIVERSITY

Please fax the complete form to: 646-756-6293
Or mail it to: Center for Women's Reproductive Care at Columbia University
Medical Records Department
1790 Broadway, 2nd Floor
New York, NY 10019
Medical Records Questions: 212-314-8812

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment 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 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) 480-2493 or the New York City Commission of 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 redisclosed by the recipient (except as noted above in Item 2), and this redisclosed 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 attorney or governmental agency specified in Item 9 (b).**
7. Name and address of health provider or entity to release this information: **Center for Women's Reproductive Care at Columbia University, 1790 Broadway, 2nd Floor, New York, NY 10019.**
8. Name and address of person(s) or category of 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) and test results.
   - ☐ Other: _____

   Include: (*Indicate by Initialing*)
   _____ Alcohol/Drug Treatment
   _____ Mental Health Information
   _____ HIV-Related Information
   _____ Genetic Testing

   (b) Authorization to Discuss Health Information:

   _____ By initialing here I authorize: _____
   Initials Name of individual health care provider

   to discuss my health information with my attorney, a governmental agency, or individual listed here:

   _____
   (Individual, Attorney/Firm, or Governmental Agency Name)
10. Reason for release of information: ☐ At request of individual
    ☐ Other: _____
11. Date or event on which this authorization will expire: _____
12. If not the patient, name of person signing form (**for minors only**): _____
13. Authority to sign on behalf of patient (**parent or legal guardian only**): _____
14. **I understand that: requests may take up to 10 days to process; there is a copying fee of $0.75 per page as permitted by applicable state and federal law; a new authorization is required upon each request for records; each partner/spouse must complete his or her own request; each partner/spouse must pick up his or her own records, unless written authorization is provided; records provided to CWRC from outside institutions will not be returned.**

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.

_____ _____

Signature of Patient or representative authorized by law (parent/legal guardian) 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.**