OCA Official Form No.: 960



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		
, , ,	t health information regarding my care and treatmen	
(HIPAA), I understand that:	the Privacy Rule of the Health Insurance Portability a	-
•	re of information relating to ALCOHOL and DR and CONFIDENTIAL HIV* RELATED INFORM	
11 1	t the health information described below includes an fically authorize release of such information to the pe	5
2. If I am authorizing the release of HIV-re prohibited from redisclosing such informati	lated, alcohol or drug treatment, or mental health to on without my authorization unless permitted to	do so under federal or state law.
inderstand that I have the right to request a li	st of people who may receive or use my HIV-related	information without authorization.

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.

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

- 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 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:			
8. Name and address of person(s) or category of person to whom this	s 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), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.			
☐ Other:	Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment		
	Mental Health Information		
Authorization to Discuss Health Information	HIV-Related Information		
(b) ☐ By initialing here I authorize			
Initials Name of individual health care provider			
to discuss my health information with my attorney, or a governmental agency, listed here:			
(Attorney/Firm Name or Governmental Agency Name)			
10. Reason for release of information:	11. Date or event on which this authorization will expire:		
☐ At request of individual	1		
☐ Other:			
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:		
All items on this form have been completed and my questions about copy of the form.	this form have been answered. In addition, I have been provided a		

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.

Signature of patient or representative authorized by law.

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.