EPISCOPAL HEALTH SERVICES INC.

HIM.240

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT ID

Patient Information:

Name: _____ DOB: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____

Definition: "Health Information": Refers to individually identifiable information (past, present or future) which is created, collected, transmitted or maintained by Episcopal Health Services Inc. ("EHS") relating to your health status, condition or treatment.

Section 1: Request Details and Information

REQUEST TYPE:

☐ Copies of Health Information/Medical Record ☐ Onsite Inspection of Health Information

☐ The Use or Disclosure of my Health Information

HEALTH INFORMATION TYPE (select "All Health Information" OR each that apply):

☐ **All Health Information** ☐ Outpatient Info. (emergency/clinic) ☐ Inpatient Info. ☐ Discharge Summary

Billing/Claims/Payment Info. Tests/Reports (ex. x-ray, labs) ☐ Other: _____

The following Health Information will not be released unless you specifically select each type below:

☐ Substance Use Disorder Information ☐ Mental Health Information (except psychotherapy notes)

☐ Genetic Testing Information ☐ HIV/AIDS Treatment Information

FROM: ☐ **EHS** ☐ **OTHER ENTITY:** _____

TO THE FOLLOWING INDIVIDUAL OR ENTITY (including yourself):

Name of Person/Entity: _____

Address: _____
(Street) (City) (State) (Zip Code)

DATE RANGE OF HEALTH INFORMATION (if applicable): **From:** _____ **to** _____

PURPOSE:

☐ Marketing ☐ Fundraising ☐ Legal Matter/Purposes ☐ Media (ex. print, radio, TV, web or social media)

☐ Training and Education (ex. sessions, journals, conferences, articles, or poster presentations)

☐ Law Enforcement Purposes Requiring Authorization/Notice (ex. reporting a crime, domestic violence, etc.)

☐ At my request (other, unspecified or elects not to provide a specific purpose)

MEANS OF HEALTH INFORMATION INTENDED TO BE USED OR DISCLOSED (select all that apply):

☐ Paper/Electronic ☐ Photo/Images ☐ Audio/Visual Recording/Filming ☐ Other: _____

Details (if applicable): _____

-Continued on Reverse Side-

EHS
EPISCOPAL HEALTH SERVICES INC.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT ID

Section 2: Copy Requests Only

FORMAT: ☐ **Paper** ☐ **CD** ☐ **Email**

Please note that CDs are not encrypted or password protected and that it is my responsibility to protect the information on the CD. Please note that there are risks associated with sending emails with this information as these methods are not considered secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

METHOD OF ACCESS: ☐ Pickup/In Person ☐ Mail to address above ☐ Fax to Individual/Entity at: _____

☐ E-mail to Named Individual/Entity named above at: _____

IMPORTANT PATIENT NOTICE

Unless revoked in writing, this authorization, which covers the use or disclosure of my Health Information shall expire three (3) years from the date of my signature below.

I understand that in some situations my Health Information could be re-disclosed and no longer protected by Federal Health Information privacy regulations and that the recipient(s) described on this form may not be required by law to protect the privacy of this information. If I am authorizing the use or disclosure of Substance Use Disorder information related to a State or Federally funded alcohol or drug use treatment individual or program, the recipient(s) is prohibited from using or re-disclosing such information without my authorization, unless permitted to do so under Federal or State law.

If I am authorizing the use or disclosure of HIV/AIDS treatment related information, the recipient(s) is prohibited from using or re-disclosing, and in some cases accessing such information without my authorization, unless permitted to do so under Federal or State law. I also understand that I have a right to request a list of those who may receive or use my HIV treatment information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS treatment related information, I may contact the NYS Division of Human Rights at 212-480-2493 or the NYC Commission of Human Rights at 212-306-7450; responsible for protecting my rights. If at any time you suspect that someone who should not have access your Health Information via an HIE, contact EHS, the HIE directly or call the NYS Department of Health at 518-474-4987. Additionally, you may contact the Compliance and Privacy Department at St. John's Episcopal Hospital, 327 Beach 19th Street, Far Rockaway, New York, NY 11691, by calling 718-869-5711 or by email at compliance@ehs.org or submit a complaint to the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775.

I understand that I have a right to a copy of this form as well as a right refuse to sign this form and that my health care, treatment, payment or benefits will not be affected by any decision or preclude my from accessing my health information.

I understand that I have the right to access my Health Information in the format requested and that if, for any reason, EHS cannot readily produce such, I will be notified within a timely matter and arrangements will be made to provide such in an alternative and mutually agreed upon format. I understand that if I request to inspect my Health Information that the Health Information Management Department is responsible for making reasonable accommodations to do such. I understand that if I request copies of my Health Information that I may be charged a reasonable cost for such request and that any fee estimates will be provided to me prior to being charged. My inability to pay may not be used as the reason to deny a request.

I understand that EHS may receive financial remuneration from a third party for marketing of products or services related to the use and disclosure of my Health Information for marketing purposes.

I understand that if I have the right to revoke this authorization at any time, except to the extent that EHS has already taken action based on my request or that the authorization was obtained as a condition for obtaining insurance coverage. I understand that if I choose to revoke or otherwise change this authorization that I must complete a new form. I understand that it is my responsibility to contact the respective Health Information Management Department regarding any questions or concerns I may have about this form.

Names & Signatures

PRINTED NAME OF PATIENT OR AGENT/GUARDIAN/SURROGATE

SIGNATURE OF PATIENT OR AGENT/GUARDIAN/SURROGATE | TIME & DATE

If an agent, guardian or surrogate is signing this form please complete the information below.

RELATIONSHIP/AUTHORITY TO ACT ON BEHALF OF PATIENT:

ADDRESS & PHONE:

Interpreter Information (if applicable)

PRINTED NAME OR IDENTIFICATION NUMBER OF INTERPRETER | TIME & DATE

PREFERRED LANGUAGE/METHOD UTILIZED | COMPANY/AFFILIATION