Kaleida Health

INDIVIDUAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 1 of 2

Patient Name

Address | Phone Number

Date of Birth | Medical Record Number | Financial Number

Patient ID Area

Form Instructions: All sections of this form **MUST** be completed.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This information may be redisclosed if the recipient(s) identified in section 7 is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.
2. If I am authorizing the release of alcohol or drug treatment, mental health or HIV-related information by placing my initials on the appropriate line in section 8, the recipient(s) 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) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting my rights.
3. I have a right to refuse to sign this authorization and my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form.
4. I have a right to receive a copy of this form after I have signed it.
5. If I sign this authorization, I have the right to revoke it at any time, except to the extent that the organization has already taken action based upon my authorization. To revoke this authorization, I must write to the Kaleida Health Privacy Officer, 726 Exchange St., Suite 200, Buffalo, New York 14210.

6. **Who will disclose the information?** Identify the Kaleida Health facility that will release your information.
   - ☐ Buffalo General Medical Center/Gates Vascular Institute
   - ☒ John R. Oishei Children's Hospital
   - ☐ Millard Fillmore Suburban Hospital
   - ☐ Laboratory Services
   - ☐ Kaleida Health Clinic at__________
   - ☐ Other (specify)__________
   - ☐ DeGraff Memorial Hospital
   - ☐ HighPointe on Michigan
   - ☐ Patient Financial Services
   - ☐ DeGraff Skilled Nursing Facility

7. **Who will receive the information?** Provide the name and address of person(s) or category of person to whom this information will be sent.
   1. Name CHC Learning Center
      Address 1085 Eggert Rd
      Amherst NY 14226
      Relationship (if applicable)__________
   2. Name__________
      Address__________
      Relationship (if applicable)__________

8. **What information will be disclosed?** Specify the information that is to be released.
   - ☐ Medical Record from (insert date)__________ to (insert date)__________
   - ☒ Other (specify) Most recent reports + Information

   Include (Indicate by Initialing): __________ Alcohol/Drug Treatment Information
   __________ Mental Health Information
   __________ HIV-Related Information

9. **What is the reason for the disclosure?** Indicate the reason for the release of information.
   - ☒ At the request of the individual
   - ☐ Other (specify)__________

10. **When will this authorization expire?** Identify the date or event on which this authorization will expire.
    Until my Child leaves CHC Learning Center.

SIGNATURE: *I have read this form and all of my questions about this form have been answered.*

Signature of Patient or Personal Representative Authorized by Law | Date

Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

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CORRESPONDENCE/ROI