NYC Health
NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability 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 the 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 redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMAITON WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND ITS EMPLOYEES, AGENTS AND CONTRACTORS.**

7. 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 send to you by other health care providers.

☐ Other: ______________________

Include: (*Indicate by Initialing*)

______**Alcohol/Drug Treatment**
______**Mental Health Information**
______**HIV-Related Information**

8. Reason for release of information: ☐ At request of individual ☐ Other:	9. **THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED BY THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:**
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been complete and my questions about his form have been answered. In addition, I have been provided a copy of the form.

______________________________________ Date: ______________________

Signature of patient or representative authorized by law.

***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.**

The Lorge School Emergency Information Verification Form

Please complete the form and sign at the bottom.

School Name: *The Lorge School*	Teacher Name: ____________	Class Number (Please circle one) 107, 108, 302, 306, 309, 310, 311, 21, 22, 23

Student's Name: ____________	Date of Birth: ____________	Sex: (circle one) Male / Female

Permanent Address: ____________	Mailing Address if different than residence: ____________ Court Orders / Legal Restrictions:

The primary or home number will be used for attendance calls.

Guardian 1: ____________ Relationship to Student: ____________	Home: ________ Work : ________	E-Mail: ____________ Cell: ____________
Guardian 2: ____________ Relationship to Student: ____________	Home: ________ Work : ________	E-Mail: ____________ Cell: ____________
Emergency 1: ____________ Relationship to Student: ____________	Home: ________ Work : ________	E-Mail: ____________ Cell: ____________
Emergency 2: ____________ Relationship to Student: ____________	Home: ________ Work : ________	E-Mail: ____________ Cell: ____________
Emergency 3: ____________ Relationship to Student: ____________	Home: ________ Work : ________	E-Mail: ____________ Cell: ____________

Health Care Provider Information (for emergency treatment when we are unable to contact you):

Contact Type	Agency Information	Contact Number / Email Address
Primary Care Doctor	Agency: ________ Contact Name: ________ Type of provider ____________	
Pyschiatrist	Agency: ________ Contact Name: ________ Type of provider ____________	
Psychotherapist	Agency: ________ Contact Name: ________ Type of provider ____________	
Foster Care Worker	Agency: ________ Contact Name: ________ Type of provider ____________	
Other Outside Support Provider	Agency: ________ Contact Name: ________ Type of provider ____________	

Does your child have health insurance coverage Yes or No? ____________	Health Information: Medical alerts / Allergies ____________ Receives daily medication during school hours (Y/N) ________
If yes, what is the name if the insurance company? ____________	Wears glasses and/or contact lenses (Y/N): ________

I, the undersigned, do hereby authorize officials of The Lorge School to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card , or parents/guardians cannot be contated, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school financially responsible for the emergency care and/or transportation of the said child.

____________ ____________ ____________
Signature Printed Name Date

Do Not Write Below This Line. For Office Use Only.

For School Use Only: NYC Student ID : ____________	Date Filed: ____________
Date Updated in Database ____________	Staff Initials: ____________