

Buffalo Otolaryngology Group, PC

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ DOB: _____

Complete Address: _____

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.

- I, the undersigned, authorize Buffalo Otolaryngology Group, PC to exchange or share the protected health information which it possesses concerning the patient named above with the following individuals, as follows:

Name(s) of Person(s) to receive access to Medical Information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Description of Information to be Shared:

- All protected health information
- Billing Information
- Specific protected health information (provide detailed description here):

In accordance with New York State Law and the Privacy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization does not include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV* RELATED INFORMATION.**
- I have the right to revoke this authorization at any time by writing to Buffalo Otolaryngology Group, PC, except to the extent that action has already been taken based on this authorization.
- I understand that information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.
- This authorization does not authorize you to discuss my health information or medical care with anyone other than the person(s) specified.
- This authorization will expire one year from the date it is signed.

REASON FOR RELEASE OF INFORMATION: At the request of the individual

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 this form.

Signature of patient or Representative
authorized by law

Date: _____

Printed Name of Patient or Representative
authorized by law
(If not the patient, state authority to sign on behalf of the patient....i.e. guardian)

*Human Immunodeficiency Virus that causes AIDS. The NY State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.