THE FARBER CENTER
FOR RADIATION ONCOLOGY
TM

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

The Farber Center for Radiation Oncology
21 West Broadway New York, NY 10007
(212) 300.0663
www.thefarbercenter.com

Patient Name	D.O.B	Social Security #
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 the Privacy Rule of the Health Insurance Portability and Accountability Act 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 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
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 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. Name and address of health provider or entity to release this information:
   The Farber Center for Radiation Oncology, 21 West Broadway, New York, NY 10007, (212) 300.0663

7. Name and address of person(s) or category of person to whom this information will be sent:

8. Specific information to be released:
   [ ] Entire Medical Record [ ] Medical Record from (insert date)_____ to (insert date) _____
   [ ] Other: _____
   Include: (Indicate by Initiating) _____ Alcohol/Drug Treatment
   _____ Mental Health Information
   _____ HIV-Related Information

9. Reason for release of information:
   [ ] Medical Care and/or Insurance [ ] Personal User
   [ ] Attorney [ ] Other:

10. This authorization will have no expiration date unless specified:

11. If not the patient, name of person signing form:

12. Authority to sign on behalf of patient:

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 the form.

Signature of patient or representative authorized by law _____ Date: _____

A COPY of this Authorization shall have the same force and effect as an original
* 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 contact