MICHELE GORLA, MD
BRIAN MCDONALD, MD
MICHELINE FORD, MD
AHMED KHAN, MD
ANTHONY SANTILLI, MD
JEHANZEB KHAN, MD
ELIZABETH LEVINE, DNP, ANP
ROSEMARY FREEMAN, FNP
VICTORIA EVERY, AGNP

Schenectady Pulmonary & Critical Care Associates

PRACTICE MANAGER: SABRINA HALSE, RRT, CPFT
Schenectady Office Coordinator: TRACY FAHY
Amsterdam Office Coordinator: CARESSA LORIA
www.spcca.com

SAEED U. KHAN, MD
EUGENE GOYKHMAN, MD
ANTHONY MALANGA, MD
ALEC PLATT, MD
NIRAJ SINHA, MD
KATHLEEN BELLIZZI, ACNP
KAREN MULHOLLAND, PA
JELANA GRISSOM, FNP

SCHENECTADY (MAIN) OFFICE: 124 ROSA ROAD SUITE 382 ● SCHENECTADY, NY 12308 ● TEL: (518) 386-3691 ● FAX: (518) 386-3553
AMSTERDAM OFFICE & SLEEP DISORDERS CTR: 116 POLAR PLAZA, RT. 30 N ● AMSTERDAM, NY 12010 ● TEL: (518) 627-0410 ● FAX: (518) 386-3553
CLIFTON PARK OFFICE: 103 SITTERLY ROAD ● SUITE 2200 ● CLIFTON PARK, NY 12065 ● TEL: (518) 386-3691 ● FAX: (518) 386-3553

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ Date of Birth: _____

Patient Acct #: _____

Patient Address: _____

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

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 7(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 7(a), I specifically authorize the release of such information to the person(s) indicated in Item 6.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing 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 re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

6. Name and address of health provider or entity to release this information:

□ **Schenectady Pulmonary Critical Care Associates** *OR* _____
124 Rosa Rd. Ste 382 _____
Schenectady, NY 12308 _____

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

□ **Schenectady Pulmonary Critical Care Associates** *OR* _____
124 Rosa Rd. Ste 382 _____
Schenectady, NY 12308 _____

(a). Specific Information to be released:

□ Medical Record from (date) _____ to (date) _____ *OR*

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes) test results, radiology studies, films, consults, billing records, and records sent to you by other healthcare providers.

□ Other _____

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

(b). Authorization to Discuss Health Information

By initialing here _____, I authorize

_____
(Name of health care Provider)

to discuss my health information with my attorney, or a government agency, listed here:

_____
(Attorney / Firm Name or Governmental Agency)

8. Authorization is valid for one year, or: _____

9. If not the patient, name of person signing form: 10. Authority to sign on behalf of the 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 this form.

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