NEW YORK STATE | Office of Mental Health

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information and Confidential HIV/AIDS-related Information)

Section I. Patient Information

Patient Name:	Date of Birth:	Medical Record #:
Patient Address:	Phone #:	Email Address:

Section II. Authorization Information

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

1. This authorization may be used for the release of all protected health information including SUBSTANCE USE DISORDER TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION. Substance use disorder treatment, mental health treatment, and HIV/AIDS-related information may only be released to the person(s) listed in item 10 only if I specifically authorize the release of such information by placing my initials on the appropriate line in item 13.
2. Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.
3. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related health, substance use disorder treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights, the agency responsible for protecting my rights, at 1-888-392-3644.
4. I have the right to revoke this authorization at any time by writing to the provider or entity listed below in item 9. I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. This authorization may be completed and signed electronically, pursuant to the Electronic Signatures and Records Act, including via a provider's electronic health record. Providers must ensure this form can be printed and/or delivered in the approved format to the patient, patient's representative, and/or intended recipients.
6. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
7. I must complete all items on this form. If any sections are left blank, this form will be invalid.
8. My questions about this form have been answered and I have been provided a copy of the form. ☐

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Section III. Release Information

9. Name and Contact Information of Provider Authorized to Release this Information:

   _____

10. Name and Contact Information of Person(s) to Whom this Information Will Be Released:

    _____

11. Purpose for Release of Information: _____

12. Unless previously revoked by me, this authorization for the release of my health information will expire on the event or date specified below:

    _____

Section IV. Health Information

13. I authorize the following Protected Health Information to be disclosed:

    ☐ Part of my Medical Record from (insert date) _____ to (insert date) _____

    ☐ Entire Medical Record, including patient histories, office notes (except separate psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

    ☐ Other (Please specify):

    _____

    For mental health treatment, SUD treatment and HIV/AIDS-related information to be released, you must check the box, initial, and date below for the specific information you want disclosed.

    ☐ Clinical records from mental health programs Initials: _____ Date: _____

    ☐ Records from SUD treatment programs Initials: _____ Date: _____

    ☐ HIV/AIDS-related Information Initials: _____ Date: _____

Section V. Signature

14. Signature of Patient or Personal Representative: _____

15. Date: _____

16. Patient Name (Printed): _____

17. If not the patient, name of Personal Representative (Printed): _____

18. Authority of Personal Representative to sign on behalf of patient: _____

    ☐ Patient declined copy

This form may be used in place of DOH2557, DOH5032, or OMH 11 and has been approved by the NYS Office of Mental Health to permit release of health information or mental health clinical records. However, this form does not require health care providers to release health information. Substance use disorder treatment, mental health treatment, or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.