RAVENA RESCUE SQUAD INC.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
REQUEST BY MAIL BY PATIENT

Patient Name	Daye of Birth	Social Security Number
Patient Address		

I, 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, **if specifically authorize release of such information to the person(s) other than me a NYS OCA Official Form No. 960 will need to be completed**.
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 Ravena Rescue Squad Inc. 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. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE UNLESS A NYS OCA OFFICIAL FORM No 960 IS COMPLETED.**

7. Patient address this information will be sent:

8. Specific information to be released:
   - ☐ Medical Records from (insert date) ____________________ to (Insert Date) ____________________
   - ☐ Entire Medical Record prior to date of request, Including patient histories, Office Notes (Except psychotherapy Notes), Test Results, Radiology Studies, Films, Referrals, Consults, Billing Records sent to Ravena Rescue Squad form Other Providers.
   - ☐ Other: ____

     ____

   Include: ***(Indicate by Initialing)***

   ________ **Alcohol/Drug Treatment**

   ________ **Mental Health Information**

   ________ **HIV-Related Information**

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 as part of the request return.

This Medical Record Release Request is being performed at the request of the Patient that received Treatment or Transport from the Ravena Rescue Squad Inc. All correspondence will be performed by mail after proper identification of the patient have been made to ensure that the person requesting the information is in fact entitled to that information. An Original signed and Notarized copy of this form will permit The Ravena Rescue Squad Inc. to mail the information to the patient at the address provided in section 7. In the event this form is sent in with a signature only and is not notarized the Medical Record will need to be picked up at the Ravena Rescue Squad in person at 5 Bruno Blvd Ravena NY 12143 with a valid form of Identification.

STATE OF (______________________)

COUNTY OF (____________________)

PATIENT SIGNATURE ____

On this __________ day of ______________________, 20___, before me personally came ____, to me known and known to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

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Notary Public

Notary Public Stamp