

INDIVIDUAL AUTHORIZATION



Patient Name: _____ ID Number: _____

Date of Birth _____ Social Security Number _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

If Hospital for Special Surgery is filling out this authorization form for you, a representative of the Hospital must answer these questions completely. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

_____ Hospital for Special Surgery
_____ Physician Office (Specify physician(s) _____
Radiology Department _____
Rehabilitation Department _____

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below.

What information will be used or disclosed? The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

Please Note: If you are requesting copies of your radiology films or images contact the Radiology Department at HSS at (212) 606-1134. They will provide you with all the necessary information and answer any questions you may have related to that request.

The following information:

The following information and/or HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV):

_____ Substance Abuse _____ Psychiatric/Psychotherapy Care _____ Sexually Transmitted Disease
_____ Tuberculosis _____ Genetic Information

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" are a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

When will this authorization expire? The date or event that will trigger the expiration of this authorization is described below.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

If you are requesting copies of your radiology films or images you must contact the Radiology Department at HSS at (212) 606-1134. They will provide you with all the necessary information and answer any questions you may have related to that request.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, but we will not be permitted to use or disclose your information as described on this form without your signature.

You have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to Health Information Management at the hospital.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

Telephone:
_____ (daytime)
_____ (evening)
Email Address (optional):

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

Authorization for Release of Confidential HIV* Related Information

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive. State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065.

If you sign this form (Individual Authorization Form), HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time by indicating your change in writing. Upon your request, the facility or provider asking for this release must provide you with a copy of this form as signed by you or left unsigned.

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1(800) 523-2437 or (212) 480-2493 or the New York City Commission of Human Rights at (212) 30&5070. These agencies are responsible for protecting your rights.

*Human Immunodeficiency Virus that causes AIDS.

FEES

Copying and Distribution Costs. We will charge you a reasonable fee to recover the costs for copying, mailing, and supplies used to fulfill your request. Our standard fee for is \$ 0.75 per page for patients (or their personal representatives) plus postage and sales tax. You will receive an invoice detailing the costs to copy your record. This invoice must be paid before your record will be mailed or sent to you (or other persons requested by you).

Note: Patients will not be charged a fee for their medical records that are mailed directly to their physicians or caregivers (for continued medical care or treatment).

PATIENT UNDERSTANDING AND SIGNATURE

By signing this form, I am requesting that Hospital for Special Surgery provide information in the manner described in this form. I understand that I will be contacted about fees for copies and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

If you have a question, please call the Medical Records Department during regular office hours between 8:00AM – 5:00PM Monday – Friday (212)-606-1254.