MERRICK FIRE DEPARTMENT, NEW YORK MEDICAL FOIL RECORDS REQUEST & HIPPA RELEASE

Dear Records Access Officer:

(1) Please send me	the following	Records if p	ossible (incl	ude as m	uch de	etail	
about the Records	possible, such	as relevant	dates, name	es, descri	ptions,	etc.)	:

- (2) Please advise me of the appropriate time during normal business hours and location for inspecting the following Records prior to obtaining copies (include as much detail about the record as possible, such as relevant dates, names, descriptions, etc.):
- (3) Please inform me of the cost of providing paper copies of the following Records (include as much detail about the record as possible, such as relevant dates, names, descriptions, etc.):
- (4) If the requested Records cannot be emailed to me, please inform me by email of the portions that can be emailed and advise me of the cost for reproducing the remainder of the Records requested (\$0.25 per page or actual cost of reproduction).
- (5) If the requested Records cannot be emailed to me due to the volume of Records identified in the response to my request, please advise me of the actual cost of copying all Records onto a CD or floppy disk.
- (6) If my request is too broad or does not adequately describe the Records, please contact me so that I may clarify my request, and when appropriate inform me of the manner in which Records are filed, retrieved or generated. If for any reason any portion of my request is denied, please inform me of the reasons for the denial in writing and provide the name, address and email address of the person or body to whom an appeal should be directed.

*Name:	
Organization	:
*Address:	
*City:	
*State:	
*Zip:	

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		
I, or my authorized representative, request that health information regarding	ng my care and treatment be rele	ased 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 9(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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 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. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL

. Name and address of health provider or entity to release this info	ormation:	
3. Name and address of person(s) or category of person to whom the	his information will be sent:	
P(a). Specific information to be released:		
Medical Record from (insert date)	to (insert date)	
☐ Entire Medical Record, including patient histories, office r	notes (except psychotherapy notes), test result, radiology studies, films,	
referrals, consults, billing records, insurance records, and i	records sent to you by other health care providers.	
Other:	Include: (Indicate by Initialing)	
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) By initialing here I authorize		
Initials	Name of individual health care provider	
to discuss my health information with my attorney, or a gove	ernmental agency, listed here:	
	Name or Governmental Agency Name)	
(Attorney/Firm	rame of Governmental regency rame)	
(Attorney/Firm 10. Reason for release of information:	11. Date or event on which this authorization will expire:	
10. Reason for release of information:		
10. Reason for release of information: At request of individual		

copy of the form.

Signature of patient or representative authorized by law.

^{*} 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 contacts.

Instructions for the Use of the HIPAA compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.