Concorde
Medical Group
Member of Northwell Health Physician Partners®

Authorization for Release of Health Information

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

1. Contact information of health care provider or entity to release this information:		
Name:	Address:	
Phone #:		
2a. Contact information of person(s) or entities who will receive this information:		
Name:	Address:	
Phone #:	Fax:	E-mail:

2b. Method of delivery for release of information:

☐ Pick-up at facility ☐ Mail ☐ Fax ☐ USB Flash Drive ☐ E-mail (to have sent by unencrypted E-mail complete page 3)

☐ Verbal ______ **PLEASE INITIAL HERE** to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.

☐ Other method of delivery (please explain): ____________________

3a. Specific information to be released:

☐ Medical Record Abstract (summary of record)

☐ Medical Record from (insert date) ____________________ to (insert date) ____________________

☐ Entire Medical Record

☐ Laboratory results for date of service ____________________

☐ Other: ____________________

3b. The following types of information will NOT be released unless you or your authorized representative initial in the appropriate spaces provided below:

____ Substance Abuse Treatment Information (including diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)

____ Mental Health Treatment Information

____ HIV-Related Information

4. Reason for release of information:

☐ At request of individual ☐ Other: ____________________

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

VD001 (6/11/19)

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Authorization for Release of Health Information

5. I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: a. I have the right to revoke this Authorization and my Permission to Send Information Requested by Unencrypted E-mail (page 3 of this document) at any time by writing to the health care provider listed in Section 1. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization. b. 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. c. Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.	
6. Date or event on which this Authorization will expire (this field must be completed with a date or event):	
7. Patient/Agent/Surrogate/Guardian* (Signature):	8. Date:
9. Printed name of person signing this form:	10. Authority to sign on behalf of patient or relationship to patient (if applicable):

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Only for use when interpreter services are utilized for the completion of this form:

Telephonic Interpreter's ID # ________ Date/Time

OR

Signature: Interpreter ________ Date/Time ________ Print: Interpreter's Name and Relationship to Patient

Witness to Signature ________ Print Witness Name

***Patients requesting information by unencrypted E-mail must complete "Permission to Send Information Requested by Unencrypted E-mail" (Form# VD001E).

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

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Permission to Send Information Requested by Unencrypted E-mail

If you are requesting health information (pursuant to the attached Authorization Form# VD001) be released via unencrypted E-mail, Northwell Health asks that you acknowledge and consent to the following:

Unless I request otherwise, E-mails containing health information sent to me from Northwell Health are encrypted to keep them secure during transmission. I understand that most personal E-mail services do not encrypt or otherwise protect E-mails and, therefore, I understand that E-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. Despite this risk, I authorize my provider to transmit the information I have requested by unencrypted E-mail.

I further acknowledge that E-mails may be inadvertently sent to the wrong address and may be subject to technical malfunctions. Therefore, I understand that E-mail delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

Patient/Agent/Surrogate/Guardian* (Signature):	Date:
Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Only for use when interpreter services are utilized for the completion of this form:

Telephonic Interpreter's ID # Date/Time
OR

Signature: Interpreter Date/Time

Print: Interpreter's Name and Relationship to Patient

Witness to Signature

Print Witness Name

**For consent regarding on-going electronic communications not related to the release of medical records, please use the "Northwell Health Consent to E-mail and Text Communications" (Form# VD032).