Catholic Health

FOR CATHOLIC HEALTH USE ONLY:

MRN: _____

Date Received: _____

Date Processed: _____

Logged By: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Authorization to Release Protected Health Information, HIM ROI AUTHORIZATION, 3/16/26

Patient Name	Date of Birth	Last 4 # of SSN (if known)
Patient Address		**Phone Number**

I, or my authorized representative, request that health care information be released as set forth on this form. In accordance with New York State (NYS) Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include the disclosure of health information relating to **Alcohol/Drug/Substance Use treatment, Mental Health treatment,** except psychotherapy notes, **HIV/AIDS treatment or testing, Genetic Testing** and **Reproductive Healthcare.** I authorize the release of such information by checking/selecting the appropriate boxes below.
2. If I am authorizing the release of any information, including information relating to **Alcohol/Drug/Substance Use treatment, Mental Health treatment, HIV/AIDS treatment or testing, Genetic Testing** or **Reproductive Healthcare**, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under Federal or NYS 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 NYS Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450.
3. Certain other health information disclosed under this authorization may be re-disclosed by the recipient and this re-disclosure may no longer be protected under Federal or NYS law.
4. I have the right to revoke this authorization at any time, in writing to Catholic Health. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization by Catholic Health.
5. Signing this authorization is voluntary and my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization.
6. Catholic Health may not release medical records or health information to anyone other than those listed on this authorization, unless permitted to do so without authorization under Federal or NYS law.
7. A person may be subject to criminal penalties pursuant to 42 USC §13 20d-6 if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to another individual or discloses such individually identifiable health information to another person.

Name of Catholic Health entity/provider to release health care information: (see Catholic Health, Medical Records website for addresses if needed)

Release/Send Health Information:
Name (and if applicable, address) of the individual (with title) and entity (if applicable) to whom this health information will be disclosed:

_____
(Name) (Full Address) (Primary Phone)

Select Format: ☐ Verbal (In Person or Phone) ☐ Paper (Mail) ☐ CD (Mail) ☐ Fax (include number): _____
☐ E-delivery (requester email address): _____
Note: E-delivery is processed via Catholic Health's Release of Information Third Party System.

Type of Health Information (select one):
☐ Medical Record / Health Information ***from*** (date) _____ ***to*** (date) _____.
☐ Complete Medical Record / Health Information, such as patient histories, encounter notes (except psychotherapy), test or lab results/reports, radiology reports, referrals, consults or other health information from Catholic Health.
☐ Other (such as radiology films or billing records): _____

Include Sensitive Health Information related to (check each box to acknowledge that certain specific health information may be included):
☐ Alcohol/Drug/Substance Use Treatment ☐ Mental Health Treatment ☐ HIV-related Treatment
☐ Genetic Testing ☐ Reproductive Health Information (see attestation below)

Reason for release of information (select all that apply):
☐ Patient/Personal Rep. Request (including sharing info. with friends or family as noted above)
☐ Treatment/Care Coordination (including to another provider/entity)
☐ Training/Education/Journal ☐ Legal ☐ Marketing/Fundraising ☐ Other: _____

Authorization Expiration: (if left blank, authorization will not expire or change unless requested)
_____ One Time Only _____ Date _____ Event

All items on this form have been completed to the best of my ability and my questions about this form have been answered. I have been provided with a copy of this form upon my request. For disclosures that include Reproductive Health Information: I understand that HIPAA prohibits the use or disclosure of reproductive health information when it is sought to investigate or impose liability on individuals, health care providers, or others who seek, obtain, provide, or facilitate reproductive health care.

Patient/Personal Representative: Signature: _____ Date & Time: _____

_____ _____
*If Personal Representative - Relationship to/Authority to Act on Behalf Of Patient Personal Representative Contact Information (if different from above)

HBG 33043 (3/16/26) 1.1

A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL