

COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP

JOHN D. NICHOLSON, MD
MICHAEL A. MOFFA, MD
DAVID A. NESBITT, MD
JAMES R. BERRY, MD

I acknowledge that I have had the opportunity to review the privacy policy of Colon Rectal Associates of CNY, LLP.

Signed _____ Date _____

FAMILY HIPAA PRIVACY FORM

HELP US PROTECT YOU

Patient Name _____ Date of Birth _____

I AGREE THAT BY CHECKING THE FOLLOWING IT IS AGREEABLE FOR THE COLON AND RECTAL ASSOCIATES OF CNY TO:

___ CALL / LEAVE MESSAGES ON HOME PHONE

___ CALL / LEAVE MESSAGES WITH ANOTHER PERSON

___ CALL / LEAVE MESSAGES ON CELL PHONE

___ CALL / LEAVE MESSAGES AT WORK

___ MAKE CONTACT THROUGH THE MAIL

I ALSO GIVE MY PERMISSION TO THE COLON AND RECTAL ASSOCIATES OF CNY TO RELEASE MEDICAL INFORMATION TO THE INDIVIDUALS LISTED BELOW:

1. _____ RELATIONSHIP _____ PHONE NO. _____

2. _____ RELATIONSHIP _____ PHONE NO. _____

3. _____ RELATIONSHIP _____ PHONE NO. _____

This authorization does not authorize you to discuss my health information or medical care with anyone other than those specified above. 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.

SIGNATURE _____ DATE _____

North Medical Center
5100 West Taft Road, Suite 4A
Liverpool, NY 13088
(315) 458-2211
Fax (315) 452-9025

Township 5
260 Township Blvd., Suite 30
Camillus, NY 13031
(315) 991-8338
Fax (315) 991-8345



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 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:

- 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.
- 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.
- 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.
- 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.
- 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.
- THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Colon Rectal Associates of CNY 5100 W Taft Rd Ste 4A Liverpool, NY 13088 Ph# 315-458-2211 Fax# 315-458-9025

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

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

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____
Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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.

Signature of patient or representative authorized by law: _____ Date: _____

* **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.**