STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

MANHATTAN DERMATOLOGY
71 Park Avenue, Ste. 1A and 36A E. 36th St. Ste. 202
New York, NY 10016
FAX: 212-689-8519

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Purpose of the Disclosure: _____

Will this information be used for marketing? Yes____ No____
Has this information been previously de-identified? Yes____ No____
Persons Authorized to Use or Disclose the Above Information: _____

_____

_____
(Name of person or organization)

Persons to Whom Information May Be Disclosed: _____
(Name of person or organization)
Address: _____

_____

Fax: _____

Expiration Date of Authorization
This authorization is effective through (check one) ☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

HIV Related information
Your Rights Related to the Release of Confidential HIV/AIDS Information Confidential HIV-related information is any information indicating that a person has had an HIV related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV. By signing this form, medical information and/or HIV-related information can be given to the people listed by you on this form, for the reason(s) listed. Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. 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 medical and/or HIV-related information are not protected under federal law. 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) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. 1

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Name of patient (Type/Print)

Signature of Patient Date

Signature of Patient Representative (if applicable)

Relationship of Patient Representative to Patient (if applicable)