World Trade Center Health Program
State University of New York, Stony Brook
1345 Motor Parkway, 1st Floor, Islandia NY 11749/Tel. (631) 855-1200/Fax (631) 630-6297
173 Mineola Blvd., Suite 302, Mineola NY 11501

Monitoring and Treatment

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize: WTC Health Program

A. To **OBTAIN** protected health information from _____ for billing and coordination of care purposes Y- N
(Name of specialty referred to)

B. To **DISCLOSE** the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

_____ W#: _____

(2) Information to be disclosed:

- □ Complete health record(s)
- □ History & physical examination
- □ Consultation reports
- □ X-ray
- □ Discharge summary
- □ Progress notes
- □ Laboratory tests
- □ Other (please specify) _____

I understand that this will include information relating to (if applicable)

- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- Behavioral health services/psychiatric care.
- Treatment for alcohol and/or drug abuse.

(Initial if applicable) _____

(3) At the request of the patient, this information is to be released to:

_____
_____
_____

For the purpose of: _____

(4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

X Initials _____

(5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(6) I may request a copy of this form after signing. X Initials _____

X Signed: _____ Date: _____
(Patient) (This form has been completed before signing)

_____ Date: _____
(Legal representative) (Relationship to patient, description of authority)

_____ Date: _____
(Signature of witness) (Relationship to patient)

Revised