HOSPITAL FOR SPECIAL SURGERY WHERE THE WORLD COMES TO GET BACK IN THE GAME

HOSPITAL FOR SPECIAL SURGERY ATTENDING PHYSICIANS

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New York, NY

INDIVIDUAL AUTHORIZATION

Patient Name: _____ **ID Number:** _____

Date of Birth _____ **Social Security Number**_____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purpose(s) described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A staff member of our office must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? Health information about you may be disclosed by a physician, nurse, or member of our office's staff.

Physician Office (Specify physician(s)) _____

Who will use and/or receive the information? The person(s) or class of persons to whom you authorize our office to disclose your health information are (please also provide us with the address and contact information of those person(s) or class of persons if you are asking us to send medical records or health information out of our office):

_____

_____

_____

What information will be used or disclosed? The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

☐ The following information:

_____

_____

_____

_____

☐ The following information and/or HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV):

_____

_____

_____ Substance Abuse _____ Psychiatric/Psychotherapy Care _____ Sexually Transmitted Disease

_____ Tuberculosis _____ Genetic Information

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" are a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

_____

_____

_____

_____

When will this authorization expire? The date or event that will trigger the expiration of this authorization is:

_____

_____

_____

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or sate medical privacy laws, those people entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you 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 your rights.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that our practice has already taken action based upon your authorization. To revoke this authorization, please write to **Nelmary Lipinski, Office Manager to Dr. Michael L. Parks.**

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

_____

_____

_____

_____

Telephone:

_____ (daytime)

_____ (evening)

Email Address (optional):

_____

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.