AdvantageCare PHYSICIANS

# HIPAA Representative Form

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPAA Representative named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below:

**Patient Information – Please Print**

Patient Name: ________________________________________ Date of Birth: ___________________

Address: ________________________________________ City/State/Zip Code:______________________

Telephone # most easily reached: ________________________________________

**HIPAA Representative Information - Please Print**

Name: ________________________________________________ Date of Birth: ________________________

Address: _______________________________________ City/State/Zip Code: _________________________

Telephone # most easily reached: ______________________________

Relationship to Patient:________________________________________

**I grant to the HIPAA Representative named above access to:**

___All of my PHI – note separate box below is also required for HIV, psychiatric and substance abuse access.

___Other - Specify limits or specific health care incident: ________________________________________

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

**I understand that the information in my medical record may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to: (you must initial each area you wish the HIPAA Representative to have access to)**

**___ Alcohol, drug, or substance abuse information**

**___ AIDS, HIV-related information (including AIDS related testing and results)**

___ **Mental Health**
___ **Sexually Transmitted Disease information**
___ **Genetic information**
___ **Research Information**

**The confidentiality of this record is required under New York State and Federal Law. This material shall not be transmitted to anyone without written consent or authorization.**

**Signature of Patient for this box:________________________________ Date: _______________**

1. I understand that I may revoke this HIPAA Representative designation at any time by notifying the Director of Health Information Management at the following address: 55 Water Street, 12th Floor, Rm 12G09, New York, NY 10041 in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by AdvantageCare Physicians prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will: (Must check one)

( ) expire 1 year from the date executed: or

( ) be effective for the lifetime of the patient unless revoked (see #1 above)

**Signature of Patient**: _______________________________________________ Date: _____________

**Signature of HIPAA Representative**: ____________________________________Date: _____________

## (Form will not be valid unless all appropriate blanks are filled)

## *YOU MAY REFUSE TO SIGN THIS FORM*