Kaleida Health

INDIVIDUAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 1 of 2

Patient Name

Address | Phone Number

Date of Birth | Medical Record Number | Financial Number

Patient ID Area

Form Instructions: All sections of this form **MUST** be completed.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This information may be redisclosed if the recipient(s) identified in section 7 is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.
2. If I am authorizing the release of alcohol or drug treatment, mental health or HIV-related information by placing my initials on the appropriate line in section 8, the recipient(s) 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) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting my rights.
3. I have a right to refuse to sign this authorization and my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form.
4. I have a right to receive a copy of this form after I have signed it.
5. If I sign this authorization, I have the right to revoke it at any time, except to the extent that the organization has already taken action based upon my authorization. To revoke this authorization, I must submit my request in writing addressed to the Kaleida Health Privacy Officer using the facility address on page 2.

6. **Who will disclose the information?** Identify the Kaleida Health facility that will release your information.
   - ☐ Buffalo General Medical Center/Gates Vascular Institute
   - ☐ John R. Oishei Children's Hospital
   - ☐ Millard Fillmore Suburban Hospital
   - ☐ Laboratory Services
   - ☐ Kaleida Health Clinic at_____
   - ☐ Other (specify)_____
   - ☐ DeGraff Medical Park
   - ☐ HighPointe on Michigan
   - ☐ Patient Financial Services
   - ☐ DeGraff Skilled Nursing Facility

7. **Who will receive the information?** Provide the name and address of person(s) or category of person to whom this information will be sent.
   1. Name_____
      Address_____
      _____
      Relationship (if applicable)_____
   2. Name_____
      Address_____
      _____
      Relationship (if applicable)_____

8. **What information will be disclosed?** Specify the information that is to be released.
   - ☐ Medical Record from (insert date)_____ to (insert date)_____
   - ☐ Other (specify)_____

   Include (Indicate by Initialing): _____ Alcohol/Drug Treatment Information
   _____ Mental Health Information
   _____ HIV-Related Information

9. **What is the reason for the disclosure?** Indicate the reason for the release of information.
   - ☐ At the request of the individual
   - ☐ Other (specify)_____

10. **When will this authorization expire?** Identify the date or event on which this authorization will expire.

    _____

SIGNATURE: *I have read this form and all of my questions about this form have been answered.*

_____ _____
Signature of Patient or Personal Representative Authorized by Law | Date

_____ _____
Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

Kaleida Health

INDIVIDUAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 2 of 2

Patient Name

Address | Phone Number

Date of Birth | Medical Record Number | Financial Number

Patient ID Area

Mailing Instructions: Send the completed form to the address of the facility identified in section #6.

Buffalo General Medical Center
Medical Records
100 High Street
Buffalo, NY 14203
(716) 859-2759

Gates Vascular Institute
Medical Records
100 High Street
Buffalo, NY 14203
(716) 859-2759

Kaleida Health Patient Financial Services
726 Exchange Street, Suite 300
Buffalo, NY 14210

Millard Fillmore Suburban Hospital
Medical Records
1540 Maple Road
Williamsville, NY 14221
(716) 568-6504

DeGraff Medical Park
Medical Records
1540 Maple Road
Williamsville, NY 14221
(716) 568-6504

Kaleida Health Laboratory Services
115 Flint Road
Williamsville, NY 14221
(716) 626-7920

John R. Oishei Children's Hospital
Medical Records
100 High Street
Buffalo, NY 14203
(716) 859-2759

HighPointe on Michigan
Medical Records
1031 Michigan Avenue
Buffalo, NY 14203
(716) 748-3163

DeGraff Skilled Nursing Facility
445 Tremont Street
North Tonawanda, NY 14120
(716) 690-2086

For locations not listed above, completed forms may be sent to BGMC Medical Records, 100 High Street, Buffalo, NY 14203.