Authorization for Release of Health Information from Brooklyn Birthing Center

Patient Name:	Date of Birth:
Patient Address:	

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 authorization may include disclosure of information relating to CONFIDENTIAL HIV / AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV / AIDS-related information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV / AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Provider (or Entity) to Release this Information:

Brooklyn Birthing Center
2183 Ocean Avenue Tel: 718-376-6655
Brooklyn, New York 11229 Fax: 718-336-4113

6. Name and Address of Provider (or Entity) to Receive this Information:

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

7. Purpose for Release of Information:

☐ Continuing medical treatment at the facility specified in Item 6

☐ Personal reasons ☐ Other: _____

☐ Litigation / attorney review ☐ Insurance: Insurance Company Name: _____ Claim File #: _____

8. I authorize the release of:

☐ Current pre-natal records including history and physical, all original lab work, and ultrasound reports.

☐ Pap and GC/CT cultures done within 6 months of current pregnancy.

☐ HIV / AIDS-related Information.

9. If not the patient, name of person signing form:	**10. Authority to sign on behalf of patient:**

All items on this form have been completed, my questions about this form have been answered, and I have been provided a copy of the form. This authorization will expire 6 months from the date hereof, unless another expiration date is specified here: _____.

Signature of Patient or Representative Authorized by Law: _____ Date: _____

Witness Statement / Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and / or the patient's authorized representative.

Staff Person's Name / Title: _____ Signature: _____ Date: _____

* Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that disclosure will not reasonably be expected to be detrimental to the patient or another person.