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AgeWell
NEW YORK

HIPPA Privacy Release Form

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Name: _____ Member ID: _____

Birthdate: _____ /_____ / _____

1. Authorization

a. I authorize **AgeWell New York** to use and disclose the protected health information described below to

_____ (individual seeking the information).

Authorization to discuss health care information: By initialing here _____ I authorize AgeWell New York to discuss my health information with the entity or person(s) listed below:

_____

_____

_____

2. Effective Period

This authorization for release of information covers the period of healthcare form:

a. ☐ _____ to _____ ** OR ** b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

** OR **

b. ☐ I authorize the release of my complete health record with the exception of the following information:

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☐ Mental health records ☐ Communicable Diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative:

Printed name of patient or personal representative and his or her relationship to patient:

Date:

/ /

Mail the form and documents to:

AgeWell New York
1991 Marcus Avenue- Suite M201
Lake Success, NY 11042

1.866.586.8044 | agewellnewyork.com

Law firms, record retrieval agencies, and third party insurance entities requesting a claims payment report for litigation or subrogation purposes, please note: you must submit a notarized authorization to receive records.