Form OMH 11 (9-10)

State of New York
OFFICE OF MENTAL HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) "C" No.

Sex Date of Birth

DR. GRIFFAN RANDALL, D.O., PLLC

Facility Name Unit/Ward/Residence No.

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Previous medical records or pertinent medical history

Purpose or Need for Information:

1. This information is being requested:
   - ☑ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or
   - ☐ Other (please describe) ______
2. The purpose of the disclosure is (please describe):

   Medical

From: Name, Address, & Title of Person/Organization/Facility/Program Disclosing Information

DR. GRIFFAN RANDALL
1809 Western Avenue
Albany, NY 12203

To: Name, Address, & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made

***NOTE:** If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*

phone #
fax #

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by *(insert name of facility/program)* DR. GRIFFAN RANDALL. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

B-1. One-Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above.

My authorization will expire:

☐ When acted upon; ☐ 90 Days from this Date; ☐ Other______

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Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.
DR. GRIFFAN RANDALL, D.O., PLLC		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ❑ When I am no longer receiving services from *(insert name of facility/program)* ____________________________ ;
- ❑ One year from this date;
- ❑ Other ____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

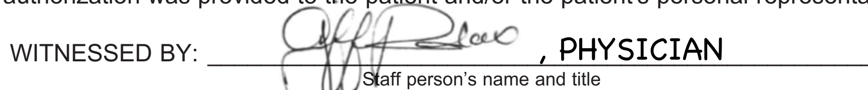
Signature of Patient or Personal Representative ____________________ Date ____________

Patient's Name (Printed) ____________________

Personal Representative's Name (Printed) ____________________

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. 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 personal representative.



WITNESSED BY: ______________________, PHYSICIAN
Staff person's name and title

Authorization Provided To: DR. RANDALL

Date: ____________________

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information

PHYSICIAN
Title

Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

____

____

____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

____

____

____

Signature of Patient or Personal Representative ____________________ Date ____________

Patient's Name (Printed) ____________________

Personal Representative's Name (Printed) ____________________

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*