

## **Instructions to Request Your Medical Records**

As a patient of Primary PartnerCare Physicians, PLLC, you have a right to access a copy of your medical records. We take your privacy seriously and take all steps to ensure your medical information is protected and held confidential.

Primary PartnerCare utilizes the HIPAA-compliant Medical Records Release form created by New York State Office of Court Administration in conjunction the medical provider community, the bench and the bar.

## Form Instructions

Please fill this form out in its entirety, sign it and date it. Some of the frequently asked questions about the form are below:

- Box 7: This box is to list the name of the entity to whom you are requesting your information be released to such as XYZ Hospital or ABC Medical Group or JFK Law Firm with their address. Please be accurate and complete when completing this Box. If you are requesting your own medical records, simply write "SELF"
- Box 8: If there is a specific person or a department where you are releasing your records in the entity listed in Box 7. For example, it might be the name of a lawyer, or a specific doctor name
- Box 9(a): If you only want specific dates sent, please indicate this. If you want certain protected information to be released such as Alcohol/Drug, Mental Health and/or HIV-Related, please initial the boxes.
- Box 9(b): If you want to give permission for your provider to speak with an attorney or governmental agency about your health information, you can initial and fill in the provider name and whom exactly they are authorized to speak with.
- Box 11: You can indicate when this authorization expires if this is important to you.
- Box 12 and 13: These Boxes are important if you are completing this form on behalf of someone else. You must indicate your name in Box 12 and the authority to request and sign in Box 13 (for example Power of Attorney)

Please fill this form out in its entirety, sign it and date it. Some of the frequently asked questions about the form are below:

OCA Official Form No.: 960



## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]		
Patient Name	Date of Birth	Social Security Number
Patient Address		
I, or my authorized representative, request that health	h information regarding my care and treatmen	t be released as set forth on this form:
In accordance with New York State Law and the Priv	vacy Rule of the Health Insurance Portability a	and Accountability Act of 1996
(HIPAA), I understand that:	C - I - I - I - A - COMOL - I - DE	NIC ADVICE MENTAL HEALTH
1. This authorization may include disclosure of it <b>TREATMENT</b> , except psychotherapy notes, and <b>CO</b>		
the appropriate line in Item 9(a). In the event the ha		• • •
initial the line on the box in Item 9(a), I specifically		•
2. If I am authorizing the release of HIV-related, a		
prohibited from redisclosing such information wit		
understand that I have the right to request a list of pe I experience discrimination because of the release or		
of Human Rights at (212) 480-2493 or the New Y		
responsible for protecting my rights.	Ç	
3. I have the right to revoke this authorization at an		
revoke this authorization except to the extent that act 4. I understand that signing this authorization is		
benefits will not be conditioned upon my authorization		and in a nearth plan, or engloring for
5. Information disclosed under this authorization r		t as noted above in Item 2), and this
redisclosure may no longer be protected by federal or		
6. THIS AUTHORIZATION DOES NOT AUTH CARE WITH ANYONE OTHER THAN THE AT		
7. Name and address of health provider or entity to	release this information:	` /
8. Name and address of person(s) or category of per	rson to whom this information will be sent:	
9(a). Specific information to be released:		
☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient hi	to (insert date)	too) toot mosulta modiala avvatudias films
, 01	e records, and records sent to you by other he	,
Other:		(Indicate by Initialing)
		Alcohol/Drug Treatment
	<del></del>	Mental Health Information
Authorization to Discuss Health Information		HIV-Related Information
(b) ☐ By initialing here I authoriz		
Initials	Name of individual healtl	h care provider

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

(Attorney/Firm Name or Governmental Agency Name)

11. Date or event on which this authorization will expire:

13. Authority to sign on behalf of patient:

to discuss my health information with my attorney, or a governmental agency, listed here:

Signature of patient or representative authorized by law.

12. If not the patient, name of person signing form:

10. Reason for release of information:

☐ At request of individual

☐ Other:

Date:

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.