KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

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

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Patient ID Area

Date: _____

Patient Address: _____ Phone Number: _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION: *DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.*

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

_____

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below (complete name and address).

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054
P: 248.357.3330
F: 248.357.3337

What information will be used or disclosed? The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this organization) can understand what information may be used or disclosed.

☐ The following information:

_____

_____

_____

☐ The following Human immunodeficiency virus (HIV)-related information (which is any information indicating you have had an HIV-related test, or have HIV infection, HIV-related illness or acquired immunodeficiency syndrome (AIDS), or any information which could indicate that you have potentially exposed to HIV):

_____

_____

_____

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" is a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

_____

FOR DISCOVERY BEFORE TRIAL

_____

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

_____

KALEIDA
HEALTH

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

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Patient ID Area

SPECIFIC UNDERSTANDINGS: By signing this authorization form, you authorize the use or disclosure of you protected health information as described above. This information may be redisclosed if the recipient(s) described on this form 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.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you 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 your rights.

It is understood that any disclosure is bound by 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of alcohol and drug abuse information to a party other than one designated above is forbidden without your additional written authorization.

You have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You have the right to see and copy the information described on this authorization form in accordance with hospital policies. You also have the right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to Kaleida Health Privacy Officer, 726 Exchange Street, Suite 200, Buffalo, New York 14210.

SIGNATURE: *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.