Diane J Sutter, MD
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HIPAA
Authorization for Use and Disclosure of Protected Health Information

This form provides information for the purpose(s) described below. It is intended to properly inform you of how the information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____, (date of birth _____) authorize the Practice to:

DISCLOSE/RELEASE TO: (Who are we able to speak to regarding your care)

Name/Relationship/Phone#: _____
Name/Relationship/Phone#: _____
Name/Relationship/Phone#:_____

The following information: (What we can discuss regarding your care, i.e. Everything)

_____

OR
OBTAIN FROM: (Previous medical records needed for your care)

Name: _____
Address: _____
Phone Number: _____

The following information: (i.e. Entire Chart, last years' records, etc.)
_____

The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization. I understand that if my records contain information about alcohol and drug abuse, mental health treatment and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record onlyif I place **MY INITIALS** on the appropriate line as set forth below.

Included in information to be released:
Alcohol/Drug Treatment: _____
Mental Health Information: _____
HIV Related Information: _____

Purpose of Information to be disclosed [If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"]:

_____

_____

This authorization shall expire upon the earlier of (i) 365 days from the date of this request or (ii) the following date_____ or (iii) the occurrence of the following:

_____

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer, at Diane J Sutter, MD, LLC at 3800 Delaware Ave., Suite 102, Kenmore, NY 14217.
I understand that revocation is not effective to the extent that the Practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under or to contest the policy itself.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me,

I hereby authorization the use or disclosure of my health information as described in this form.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority