OCA Official Form No.: 960



□ Medical Record from (insert date) to (insert date) to (insert date)   □ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films referrals, consults, billing records, insurance records, and records sent to you by other health care providers. □ Other: Include: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information Mental Health Information HIV-Related Information	Patient Name	Date of Birth	Social Security Number
n accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 HIPAA). I understand that:  1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV® RELATED INFORMATION only if I place my initials on he appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I mitial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.  2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I mederstand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are esponsible for protecting my rights.  3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may evoke this authorization except to the extent that action has already been taken based on this authorization.  4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for penefits will not be conditioned upon my authorization of this disclosure.  5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this edisclosure may no longer be protected by federal or state law.  5. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS M	Patient Address	I	<u> </u>
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Authorization to Discuss Health Information HIV-Related Information			
	(b) By initialing here Initials  Initials  to discuss my health information with my attor		F //

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:

Signature of patient or representative authorized by law.

10. Reason for release of information:

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

☐ At request of individual

☐ Other:

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.

## Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.