

SOHO OB/GYN PC  
430 W. Broadway Suite2A  
New York, New York 10012  
Phone # (212)941-0011  
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**Authorization Form**

We understand the information about you and your health is personal and we committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us to 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. Our medical records department is available to answer any questions regarding this information.

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

1. Information to be disclosed to:

Information to be given by:

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

2. Information to be disclosed:

- A. \_\_\_\_\_ Complete Medical Records
- B. \_\_\_\_\_ Progress notes
- C. \_\_\_\_\_ Consultation Reports
- D. \_\_\_\_\_ Operative Reports
- E. \_\_\_\_\_ Radiology Reports (Mammograms, Bone Density, Other)
- F. \_\_\_\_\_ Laboratory Tests (Blood Work, Pap results, Etc.)
- G. \_\_\_\_\_ Billing Report

3. New York State regulations [NY Public Health Law 2782(1)(b)] require a special authorization for release of information regarding mental health, and HIV related condition (including HIV related tests, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse. I understand that that this authorization will expire in six months from the date this form is signed, unless otherwise stated below:

Expiration Date: \_\_\_\_\_

By signing this form, you the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of this information. If you are authorizing the release of HIV related information, you should be aware of the recipient(s) is prohibited from re-disclosing any HIV related information without your authorization, unless permitted to do so under the Federal and State Law.

Name of patient (print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient: \_\_\_\_\_