INFORMATION AUTHORIZATION FORM

At Care Design NY (CDNY) we understand that information about you and your family is personal. We are committed to protecting your privacy and that of your records. Please see Care Design NY's Notice of Privacy Practices for additional information.

This authorization is written permission for _____ to use or
(Name of Organization to use/disclose)

disclose protected health information (PHI) to: _____
(Name of organization or person to receive PHI)

in regard to _____ as directed below:
(person's name and DOB)

Specific information to be used and/or disclosed:

_____

_____

_____

_____

The Protected Health Information is being used and/or disclosed for the following purposes:

_____

_____

This authorization shall be in effect until _____, or until _____;
(date) (event)
at which time this authorization to use or disclose the protected health information expires.

Statement of Rights:

A. I understand that I have the right to revoke this authorization at any time, in writing, to the Organization which I receive services.
B. I understand that the revocation is only effective after it is received and recorded by the Organization and is not effective to the extent that Care Design NY (CDNY) has already relied upon the authorization and that CDNY will act on the revocation as described in their privacy notice.
C. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
D. CDNY will not condition my treatment, payment, or enrollment in services on whether I provide authorization for the requested use of disclosure of my records.

In reference to: _____
(person)

E. I understand that I have a right to:
- Inspect or request a copy of the protected health information to be used or disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

A photocopy or copy received by facsimile or electronically transmitted will be accepted with the same authority as the original.

_____ _____
Signature of Person or Personal Representative Date

_____ _____
Printed Name of Person or Personal Representative Description/Relationship of Personal Representative.

Form Date: 6/28/2018