Authorization for Release of Health Information (Including Alcohol/Drug Treatment

NEW YORK STATE OF THE PROPERTY OF THE WAY	lental Health In	formation) ar	nd Confidential HIV/AIDS-	related Information
BLAYK, BONZE ANNE ROSE A00088571823 M000597460 05/01/1956 62 F	Dat	te of Birth	Patient Identification Numb	per
Ehmke, Clifford BSU 202-01	•			
2.198.001.1801.8801.8801.8800.1800.1800.1				
I, or my authorized representative, request that health infor	rmation regarding my	care and treatment	be released as set forth on this form	n. I understand that:
1. This authorization may include disclosure of information relat HIV/AIDS-RELATED INFORMATION only if I place my initial types of information, and I initial the line on the box in Item 8 2. With some exceptions, health information once disclosed ma treatment, or mental health treatment information, the recipie without my authorization unless permitted to do so under fed information, I may contact the New York State Division of Hu	als on the appropriate lin s, I specifically authorize by be re-disclosed by the ent is prohibited from re deral or state law. If I ex	e in item 8. In the everelease of such info e recipient. If I am au- disclosing such info perience discriminat	vent the health information described be ormation to the person(s) indicated in Ite uthorizing the release of HIV/AIDS-relat ormation or using the disclosed information because of the release or disclosur-	elow includes any of these em 6. led, alcohol or drug ion for any other purpose e of HIV/AIDS-related
I have the right to revoke this authorization at any time by extent that action has already been taken based on this authorization.	writing to the provider			
 Signing this authorization is voluntary. I understand that gene my authorization of this disclosure. However, I do understand 	erally my treatment, pay	1.52		
5. Name and Address of Provider or Entity to Re Tompkins County Mental Health Cl			aca, NY 14850	
6. Name and Address of Person(s) to Whom th Cayuga Medical Center,101 Dates D				
7. Purpose for Release of Information: Informati	ion sharing between	n parties to co	ordinate treatment and disc	harge planning
Unless previously revoked by me, the specific information All health information (written and oral), except:	on below may be discl			9/19 IT EXPIRATION DATE OR EVENT
For the following to be included, indicate the specific information to be disclosed and initial below.		Information	on to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs				
Clinical records from mental health programs*				BARB
HIV/AIDS-related Information				
9. If not the patient , name of person signing form:		10. Authority t	to sign on behalf of patient:	
All items on this form have been completed, my que	estions about this fo	rm have been an	nswered and I have been provide	ed a copy of the form.
SIGNATURE OF PATIENT OF REPRESENTATIVE AUTHORIZED	BY LAW			10(15(18)
Witness Statement/Signature: I have witnessed authorization was provide			n and state that a copy of the sent's authorized representative.	
S C Q , RV STAFF PERSON'S NAME AND TITLE	<u>S</u>	egeth	ur RV	10/15/18
STALL LEUSON S NAME WAD THE	316	INTIUNE		DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

NEW YORK STATE DEPARTMENT OF HEALTH and Mei	ntal Health Information) and	Confidential HIV/AIDS-re	lated Information
P: BLAYK, BONZE ANNE ROSE A00088571823 M000597460	Date of Birth	Patient Identification Number	
Pi Fhmko Cl/55			
Ennike, Clifford BSU 202-01			A STATE OF THE STA
I, or my authorized representative, request that health information	ation regarding my care and treatment b	e released as set forth on this form. I	understand that:
This authorization may include disclosure of information relating			
HIV/AIDS-RELATED INFORMATION only if I place my initials or types of information, and I initial the line on the box in Item 8, I s	Const. 1777 1971 207 107 107 107 107 107 107 107 107 107 1		AND THE PARTY OF T
With some exceptions, health information once disclosed may be			
treatment, or mental health treatment information, the recipient	is prohibited from re-disclosing such inform	nation or using the disclosed information	for any other purpose
without my authorization unless permitted to do so under federa			HIV/AIDS-related
information, I may contact the New York State Division of Huma 3.1 have the right to revoke this authorization at any time by wri			thorization except to the
extent that action has already been taken based on this authorize			
 Signing this authorization is voluntary. I understand that general my authorization of this disclosure. However, I do understand the 			not be conditional upon
		unistances in ruo not sign this consent.	
 Name and Address of Provider or Entity to Rele- Cayuga Medical Center, 101 Dates Drive 			
Name and Address of Person(s) to Whom this	Information Will Bo Disclosed:		
Tompkins County Mental Health Clini		a, NY 14850	
7. Purpose for Release of Information: Information	sharing between parties to coor	dinate treatment and discha	rge planning
8. Unless previously revoked by me, the specific information			19 XPIRATION DATE OR EVENT
☐ All health information (written and oral), except:			
For the following to be included, indicate the specific information to be disclosed and initial below.	Information	to be Disclosed	Initials
Records from alcohol/drug treatment programs			
Clinical records from mental health programs*			BARB
HIV/AIDS-related Information			
9. If not the patient , name of person signing form:	10. Authority to	sign on behalf of patient:	
All items on this form have been completed, my question	ons about this form have been ansi	wered and I have been provided a	copy of the form.
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY	LAW		10/12/118
Witness Statement/Signature: I have witnessed th		and state that a conv of the ciar	ned
	d to the patient and/or the patient		icu
Sea, RN	Seget	her, RV	10/15/18
STAFF PERSON'S NAME AND TITLE	SIGNATURE		DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Authorization for Release of Health Information (Including Alcohol/Drug Treatment

NEW YORK STATE DEPARTMENT OF HEALTH and Mental	Health Information) a	nd Confidential HIV/AIDS-related Inform
BLAYK, BONZE ANNE ROSE	Date of Birth	Patient Identification Number
A00088571823 M000597460		
05/01/1956 62 F		<u>'</u>
Ehmke, Clifford BSU 202-01		
or my authorized representative, request that health information	regarding my care and treatmen	t be released as set forth on this form. I understand that:
This authorization may include disclosure of information relating to A		
HIV/AIDS-RELATED INFORMATION only if I place my initials on the types of information, and I initial the line on the box in Item 8, I speci		to the same of the
With some exceptions, health information once disclosed may be re-		
treatment, or mental health treatment information, the recipient is pro-	the state of the s	The state of the s
without my authorization unless permitted to do so under federal or s	state law. If I experience discrimina	tion because of the release or disclosure of HIV/AIDS-related
information, I may contact the New York State Division of Human Rig		
I have the right to revoke this authorization at any time by writing the extent that action has already been taken based on this authorization		5. I understand that I may revoke this authorization except
Signing this authorization is voluntary. I understand that generally my		a a health plan, or eligibility for benefits will not be conditional
my authorization of this disclosure. However, I do understand that I r	may be denied treatment in some of	ircumstances if I do not sign this consent.
5. Name and Address of Provider or Entity to Release	this Information	
Cayuga Medical Center, 101 Dates Drive		
Cayaga Medicai Center, 101 Dates Diffe	1111deu, 111 11000	
 Name and Address of Person(s) to Whom this Info Dr. Breiman, Family Medical Associates 	rmation Will Be Disclosed:	
7. Purpose for Release of Information: Information sha	aring between parties to co	ordinate treatment and discharge planning
B. Unless previously revoked by me, the specific information below All health information (written and oral), except:		9/18 until 09/19/19 F START DATE UNTIL 09/19/19 INSERT EXPIRATION DATE OF
For the following to be included, indicate the specific information to be disclosed and initial below.	Informat	on to be Disclosed Initia
	mornia	
Records from alcohol/drug treatment programs		
Clinical records from mental health programs*		BAK
HIV/AIDS-related Information		
/ HIV/AIDS-related Information		
. If not the patient , name of person signing form:	10. Authority	to sign on behalf of patient:
Il items on this form have been completed, my questions	about this form have been a	nswered and I have been provided a copy of the fo
1 corse aute		10/15/
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW		DATE
/itness Statement/Signature: I have witnessed the ex	xecution of this authorization	on and state that a copy of the signed
		ent's authorized representative.
sea and	SRO	10/15
STAFF PERSON'S NAME AND TITLE	SIGNATURE	DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

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F	BLAYK, BONZE ANNE ROSE	Date of Birth	Patient Identification Number
F	A00088571823 M000597460 05/01/1956 62 F		
	Ehmke, Clifford BSU 202-01		
	my authorized representative, request that health inform	nation regarding my care and treatment he releas	end as set forth on this form. Lunderstand that:
	his authorization may include disclosure of information relati IIV/AIDS-RELATED INFORMATION only if I place my initial:	THE MILE OF A DEC. OF PARTY AND SHOW IN	
	rpes of information, and I initial the line on the box in Item 8,		The state of the s
-	/ith some exceptions, health information once disclosed may		
tr	eatment, or mental health treatment information, the recipie	nt is prohibited from re-disclosing such information o	r using the disclosed information for any other purpose
W	ithout my authorization unless permitted to do so under federate	eral or state law. If I experience discrimination becau	se of the release or disclosure of HIV/AIDS-related
in	formation, I may contact the New York State Division of Hu	nan Rights at 1-888-392-3644. This agency is respo	ensible for protecting my rights.
	have the right to revoke this authorization at any time by watent that action has already been taken based on this authorized.	7	erstand that I may revoke this authorization except to the
4. Si	igning this authorization is voluntary. I understand that gene	rally my treatment, payment, enrollment in a health p	olan, or eligibility for benefits will not be conditional upon
m	y authorization of this disclosure. However, I do understand	that I may be denied treatment in some circumstance	ces if I do not sign this consent.
5.	Name and Address of Provider or Entity to Re	ease this Information:	
	Dr. Breiman, Family Medical Associ		
6.	Name and Address of Person(s) to Whom thi	s Information Will Be Disclosed	
٠.	Cayuga Medical Center, 101 Dates D		
	Cayaga Medicai Center, 101 Bates E	1110 1111000, 111 11000	
7.	Purpose for Release of Information: Information	on sharing between parties to coordinate	e treatment and discharge planning
8. 1	Jnless previously revoked by me, the specific informatio	n below may be disclosed from: 09/19/18	until 09/19/19
		INSERT START DA	TE INSERT EXPIRATION DATE OR EVENT
1	All health information (written and oral), except:		
	or the following to be included, indicate the specific	Information to be	Disclosed Initials
"	normation to be disclosed and mittal below.	illiointation to be	Disclosed
Į	Records from alcohol/drug treatment programs		
1	Clinical records from mental health programs*		(2402)
	Cililical records from mental nealth programs		Corres
1	HIV/AIDS-related Information		
9. 1	f not the patient , name of person signing form:	10. Authority to sign of	on behalf of patient:
	, , ,	l containent, to eight	zonan or panem
All i	tems on this form have been completed, my ques	tions about this form have been answered	and I have been provided a copy of the form.
	X a A 4		115110
	SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED B	Y LAW	LO(1) / 18
			and the decree of the comment
vit	ness Statement/Signature: I have witnessed	the execution of this authorization and st ed to the patient and/or the patient's autl	
	S a a a		10/15/18
	JLY, KN	26dethe	1. 1.0
	STAFF PERSON'S NAME AND TITLE	SIGNATURE	DATE

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