APPENDIX C

HIPAA Authorization to Allow Trustee's Doctor to Give Information to Facilitate Change of Trustee

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 C.F.R. § 164.508.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment, payment or services to ______________ to release the protected health information of:

PATIENT: ______________

DATE OF BIRTH: ______________

PHONE #: ______________

ADDRESS: ______________

____

The information is to be released to:

NAME: ______________

ADDRESS: ______________

____

PHONE #: ______________

The information I wish to have released is (include dates of service):

____

[New York–required information below]

I do ☐ I do not ☐ wish to have information about HIV/AIDS released under this authorization.

I do ☐ I do not ☐ wish to have information about drug/alcohol abuse treatment released under this authorization.

If the authorized releasor is in possession of records from another provider, I do ☐ I do not ☐ wish to have those records released under this authorization.

SAMPLE