□ 1900 Ridge Road, West Seneca, NY 14224 Tel: 716.712.0670 Fax: 716.712.0674
□ 2075 Sheridan Drive, Kenmore, NY 14223 Tel: 716.447.6474 Fax: 716.447.6433

HealthWorks-WNY-LLP: Authorization For Release of Information To Employer/TPA Pursuant To HIPAA

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ SS#: _____

Local Address: _____ City: _____ State: _____ Zip Code: _____

Local Phone: _____ Date of Birth: _____ Gender: _____

Emergency Contact: _____ Phone No.: _____ Primary Physician: _____

Employer/TPA Information:

Employer/TPA: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____ Occupation: _____

1. I authorize in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   HealthWorks-WNY, LLP (Addresses as noted above)
3. The type of information to be used or disclosed may include any of the following:

   Complete health records, Lab results/X-ray reports, Physical Examination, Immunization record, Drug / Alcohol Screening Reports, & Consultation reports.

   Other (please specify): _____
4. **You are permitted to disclose to the Employer/TPA listed above information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if specifically initialed below:**

(Please indicate by initialing)	_____ **ALCOHOL and DRUG ABUSE**
	_____ **MENTAL HEALTH TREATMENT**
	_____ **HIV RELATED INFORMATION**

   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 understand that I have the right to request a list of people who may have receive or use my HIV-related information without authorization. If I experience discrimination because of the release of 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 responsible for protecting my rights.
5. This information may be disclosed to the Employer/TPA listed above for the purpose of determining fitness for duty / pre-employment physical evaluation.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by writing to the Privacy Officer, Phillip Woeppel, at HealthWorks-WNY, 1900 Ridge Road, West Seneca, New York, 14224.. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer for HealthWorks-WNY, LLP: Phillip Woeppel, Director of Human Resources, 1900 Ridge Road, W. Seneca, NY 14224 or by telephone at (716) 712-0670.

   All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided with a copy of this form.

_____ _____

Signature of patient or legal representative | Signature of witness

Date: _____ Time: _____ Date: _____ Time: _____

Parent/Guardian Signature
(If patient is a minor): _____ Relationship: _____