Instructions: Complete all applicable sections and submit to New York Blood Center by mail, email, or FAX:

Mail:	*Email:*	*FAX:*
New York Blood Center, Attn: Privacy Officer *301 East 67th St., New York, NY 10065*	PrivacyOfficer@nybc.org	*516-478-5040*

***Patient Information** please print:*

First name:	Last name:	Middle init:	Date of Birth:

Street Address:	Apt. #:	City:	State:	Zip Code:

Phone number(s):	Preferred email address:

I hereby authorize and give consent to New York Blood Center and its respective agents and employees to furnish the medical record specified below to the following person(s), agencies or organizations:

	Name:	Address:	
1	Phone:	Fax:	Email:
	Name:	Address:	
2	Phone:	Fax:	Email:

Requested delivery method for information to be released	☐ Pick up at facility	☐ Mail	
	☐ Fax	☐ Email	
	☐ **Verbal** if *checked, **initial here** to authorize NYBC to discuss the requested health information with the person or organization representative specified above.* ▶		***Initials:***
	☐ **Other** *(describe):*		

Specific Information to be released	☐ All Records	From (start date):	To (end date)
	☐ Only the records listed here: ▶		

			Initials:
Information listed here, if available, will **NOT** be released unless you or your authorized representative check and initial in the appropriate spaces	☐	HIV-Related Information	
	☐	Mental Health Information	
	☐	Alcohol/Drug Treatment	

Release of information is authorized for these purposes	☐	At my request
	☐	Other *(describe*):

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- I have the right to revoke this Authorization at any time by giving written notice to NYBC. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.
- I understand that signing this Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

Expiration: Date or event that will trigger this Authorization to expire:	☐	1 year from today
	☐	On this date ▶
	☐	At the conclusion of this event ▶

Signature: Patient/Agent/Surrogate/Guardian	*The **patient's** signature must be obtained unless he/she is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions.*	Date:
Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):	

*Only for use when **interpreter services** are utilized for the completion of this form:*

Telephonic Interpreter's ID number:			Date:	Time:
In-person Interpreter Information	Signature:		Date:	Time:
	Printed name:	Relationship to Patient:		
Witness Information	Witness to Signature:	Print Witness name:		