



# TULLY RINCKEY PLLC

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## REQUEST FOR AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION PURSUANT TO HIPPA, 45 CFR 164.502

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Telephone: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to disclose my Protected Health Information (as applicable: Emergency Room Records, X-Rays, History & Physical Exam, Operative Reports & Pathology, Discharge Summary, Progress Notes, Labs & Tests, Nurses' Notes, Billing Info.) to:

Richard E. Rowlands, Esq.  
Tully Rinckey PLLC  
441 New Karner Road  
Albany, New York 12205

The information disclosed to and used by the above is to be utilized for the following purpose(s):

\_\_\_\_\_  
This authorization is limited to the following dates of treatment or treatment for the following conditions(s): \_\_\_\_\_

**I understand that the information disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS, HIV information, as applicable and all billing information related to treatments and services received.**

**I understand that there is a potential for information disclosed pursuant to this authorization to be subject to further disclosure by the recipient if not required by law to protect the privacy of the information.**

This authorization shall expire on \_\_\_\_\_, 200\_\_\_\_. I understand that I have the right to revoke this authorization at any time, but must do so in writing, sent to the provider of medical care that has been authorized to disclose my protected health information. I understand that revocation is not effective to the extent action was taken in reliance on this authorization and prior to receipt of any written revocation.

I acknowledge that I have signed this authorization voluntarily and that I have been provided with a copy of this authorization.

Dated: \_\_\_\_\_  
Patient

