CNY FERTILITY CENTER
Integrative Fertility Care
www.cnyfertility.com
Robert J. Kiltz, MD, FACOG
Founder and Director

Syracuse Office:
195 Intrepid Lane
Syracuse, NY 13205
800.539.9870

Albany Office:
38A Old Sparrowbush Rd.
Latham, NY 12110
866.375.4589

Rochester Office:
2244 East Avenue
Rochester, NY 14610
585.244.1280

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

An additional authorization (NYS DOH - 5032) is required for disclosures when your medical records contain information relating to Alcohol and/or Drug Treatment, Mental Health Treatment, or Confidential HIV/AIDS information including but not limited to test results and the fact that the test was taken.

Client Name:

Client Address: ______________________________ ________ ________
City State Zip Code

Client Date of Birth: ______/______/______ Phone #: (_____) _______ - _______

Medical Record Number:

I hereby authorize:

- ☐ **CNY Fertility, PLLC**
- ☐ **Other Healthcare Provider (specify):** ______________________________
  (include address and phone/fax numbers) ______________________________

To release:

- ☐ **Protected Health Information** **and/or**
- ☐ **Sensitive Protected Health Information (HIV/AIDS-related information, Substance Abuse Treatment, or Mental Health Treatment information)** ***REQUIRES COMPLETION OF ADDITIONAL AUTHORIZATION FORM NYS DOH-5032***

Pertaining to my (check one or more as applicable):

- ☐ Outpatient / Office Visit(s) **(date range)** ____/____/____ to ____/____/____
- ☐ Hospital Admission **(discharge date)** ____/____/____
- ☐ Emergency Department visit **(date)** ___/___/___
- ☐ Ambulatory/Outpatient admission **(date)** ___/___/___
- ☐ All medical records related to Fertility Treatments
  Date(s) of treatment ____/____/____

I authorize disclosure of the following information from my medical record (check, where applicable list type and date):

- ☐ History & Physical ______________________________
- ☐ Lab Test Results & Reports ______________________________
- ☐ Radiology & Imaging Reports ______________________________
- ☐ Clinical Documentation ______________________________
- ☐ Pathology Reports ______________________________
- ☐ Operative Reports ______________________________
- ☐ Discharge Summary ______________________________
- ☐ Billing Records ______________________________
- ☐ Image (of Client and/or Client's Child) and other Client-Identifiable Information ______________________________
- ☐ Other (describe) ______________________________

  OR

- ☐ Entire copy of medical record

From my medical records to:

Name of organization or person: Robert J. Kiltz, M.D. / CNY Fertility Center
Address: 195 Intrepid Lane
City: Syracuse **State:** NY **Zip Code:** 13205
Telephone (Area Code and Number): (315) 469-8700 **Fax (Area Code and Number):** (315) 469-6789

The purpose(s) for which disclosure is authorized (check where applicable):

☐ **Medical Care**
☐ **Insurance Coverage**
☐ **Personal**
☐ **CNY Fertility, PLLC Subsidized Marketing Communications**
☐ **For Use on CNYFC Social Media Platforms**
☐ **Other (specify)**______________________________

I understand that:

1. CNY Fertility, PLLC will not condition treatment, payment for services, or eligibility for services on whether I provide Authorization for any requested disclosure by CNY Fertility, PLLC.
2. **I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee as described in our Notice of Privacy Practices.**
3. This Authorization is voluntary and that I have the right to refuse to sign it.
4. PHI released pursuant to this authorization may include records generated by another healthcare provider or facility which are now part of my CNY Fertility, PLLC medical record.
5. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practices; however such revocation would not affect any action taken by CNY Fertility, PLLC in reliance on this Authorization before receipt of my written revocation.
6. **This Authorization will expire on _____/_____/_____ (fill in date if less than 1 year) or 1 year after being signed.**
7. The information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
8. My medical records may contain genetic testing information including test results.
9. I have the right to receive a copy of this authorization.

____ ____/____/____
Signature of client/personal representative (eg., legal guardian) Date

____
Print name. If personal representative, indicate relationship to client.

____
Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court.)

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

NEW YORK STATE DEPARTMENT OF HEALTH **and Mental Health Information) and Confidential HIV/AIDS-Related Information**

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8, I specifically authorize release of such information to the person(s) indicated in item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. Any unauthorized further disclosure of HIV/AIDS-related information in violation of state law may result in a fine or jail sentence or both. For alcohol and substance abuse re-disclosure, Federal Confidentiality rules (42 CFR part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:		
6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:		
7. Purpose for Release of Information:		
8. Unless previously revoked by me, the specific information below may be disclosed from: INSERT START DATE______________ until INSERT EXPIRATION 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. ☐ Records from alcohol/drug treatment programs	**Information to be Disclosed**	**Initials**
☐ Clinical records from mental health programs*		
☐ 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 questions about this form have been answered and I have been provided a copy of the form.

____ ____________________

SIGNATURE OF PATIENT OR REPRSENTATIVE AUTHORIZED BY LAW DATE

Witness/Statement Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

______________________ ______________________ ____________________

STAFF PERSON'S NAME & 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 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 indentified 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.