akira
MEDICAL IMAGING + WELLNESS

Authorization for Release of Health 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 redisclosed 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 redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. 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:
Akira Medical Imaging + Wellness • 400 Patroon Creek Blvd. Suite 104 • Albany, NY 12206

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 may be disclosed from: _____ until _____ .

☐ All health Information (written and/or oral) except: _____

For the following information to be disclosed to the party set forth above, please indicate the information to be disclosed and initial below.

☐ _____Records from alcohol/drug treatment programs _____

☐ _____Clinical records from mental health programs _____

☐ _____HIV/AIDS related information _____

☐ _____Genetic testing records _____

9. If not 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 Patient/ Legal Representative 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.

_____ _____ _____
Witness Signature Date