ROCHESTER
REGIONAL HEALTH
Laboratories

RELEASE OF LABORATORY RESULTS: REQUEST INSTRUCTIONS FOR PATIENT

- Complete form as indicated:
  - Patient Name, Date of Birth (SSN is **NOT** required)
  - Patient Address
  - Box 8: Indicate who ACM should send the results to and how you would like to receive your lab results:

    1. Via US Mail – indicate complete mailing address

       OR
    2. For signature required delivery, indicate complete mailing address and 'Certified Mail – Signature Confirmation'

       OR
    3. Via encrypted email – indicate who ACM should send results to and the email address. Encrypted results will be sent using a secure service and the results can be obtained after creating a secure login and password

       OR
    4. Pick up at ACM headquarters – Contact ACM compliance at 585-429-1985 and request pickup at 160 Elmgrove Park, Rochester, NY 14624. Photo ID is required at time of pickup.

  - Box 9(a): Indicate the specific lab results you are requesting (Medical Record range of service dates, Entire Medical Record or Other (specific date of service, specific doctor, etc...).
    - Results for alcohol/drug treatment, mental health and/or HIV-related information will not be released unless you initial the lines preceding each of these types of tests as indicated within box 9(a) on the form.
  - Box 9(b): Not applicable
  - Box 10: Optional
  - Box 11: Requests are normally valid for 1 year from the date the request is signed. If an earlier expiration is desired, indicate date.
  - Box 12: If person signing is other than patient, print name of person signing.
  - Box 13: Indicate authority given to sign on behalf of the patient (e.g. Power of Attorney, Parent, etc.).
  - Authorized agents may be contacted to satisfy requirements to establish authority to receive the patient's results.
  - Sign and date request

- You may mail or fax the request to:

  ACM Quality Assurance
  160 Elmgrove Park
  Rochester, NY 14624
  Fax: 1-585-247-7735

  OR

  Drop off at any ACM Patient Service Center

Please Note.

- ACM has 30 days to fulfill your request.
- Pre-employment or employment related testing will not be released.
- ACM cannot interpret test results for you. Please contact your ordering provider with any questions about your results. You can also refer to www.labtestsonline.org to read about the testing you had performed.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security 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:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. 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 receive or use my HIV-related information without authorization. If I experience discrimination because of the release or 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.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. 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.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.