UNIVERSAL PRIMARY CARE

SOUTHERN TIER COMMUNITY HEALTH CENTER NETWORK • (716) 375-7500 • WWW.UPCHEALTH.NET

135 N. Union St, Olean, N.Y. 14760 | 132 West Main St, Cuba, N.Y. 14727 | 9864 Luckey Dr, Houghton, N.Y. 14744 | 445 Broad St, Salamanca, N.Y. 14779 | 159 Interstate Pkwy, Bradford, P.A. 16701

# HIPAA Privacy Authorization

**Patient Name:** ______________________ **DOB:** __________

**Mailing Address:** ______________________ **Apt:** __________

**City:** ______________________ **State:** __________ **Zip code:** __________

**Home Phone:** __________ **Cell Phone:** __________ **Work Phone:** __________

**Email Address:** ______________________ **Portal Access:** Yes☐ No☐

I, ______________________ , grant the individual(s) named below permission to access my protected health information with the purpose of treatment, care, and scheduling as described in accordance with New York State Law and the Privacy Rule of the Health Insurance portability and Accountability Act of 1996 (HIPAA) And understand and acknowledge the following:

- I understand that I have the right to refuse authorization of consent to share information except in the case where this information is used for treatment, payment, or eligibility for benefits.
- I understand that Universal Primary Care is not liable if disclosed information is redisclosed by patient authorized parties and that this redisclosure may no longer be protected by federal or state law.
- I understand that I have the right to revoke my authorization at any time. Revoking consent must be submitted in writing to Universal Primary Care. Upon receipt of notice UPC will not share any future information with identified recipient but cannot be held liable for information shared prior to revocation date.

| | | | |
|---|---|---|---|
| **Legal Guardian:** __________ | | **Relationship:** __________ | |
| **Contact Phone:** __________ | **Release:** | ☐No Restrictions<br>☐Restrict Substance Use | ☐Restrict Sexual Health Info<br>☐Restrict Mental Health Info |
| **Contact Name:** __________ | | **Relationship:** __________ | |
| **Contact Phone:** __________ | **Release:** | ☐No Restrictions<br>☐Restrict Substance Use | ☐Restrict Sexual Health Info<br>☐Restrict Mental Health Info |
| **Contact Name:** __________ | | **Relationship:** __________ | |
| **Contact Phone:** __________ | **Release:** | ☐No Restrictions<br>☐Restrict Substance Use | ☐Restrict Sexual Health Info<br>☐Restrict Mental Health Info |

*Note: If restrictions are not identified it will be assumed that all information can be shared with designated recipient.

**Signature of Patient or Legal Guardian:** ______________________

**Printed Name:** ______________________ **Date:** __________

**Relationship to Patient (if applicable):** ☒Parent ☐Legal Guardian ☐Power of Attorney ☐Other