OCA Official Form No.: 960

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:
Transformational Medicine and Spa by Dr Torpey 1159 Pittsford-Victor Road, Ste 160, Pittsford, NY 14534

9(a). Specific information to be released:

HIPAA secure Fax to (833)973-5947

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, 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 _____ I authorize _____

Initials — 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: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
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.**

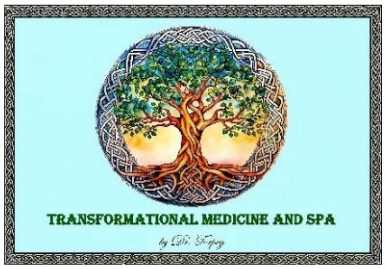
Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

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.



Laurence E. Torpey, M.D.
Transformational Medicine and Spa by Dr. Torpey
1159 Pittsford-Victor Road, Suite 160
Pittsford, NY 14534
Phone (585) 267-7148
Fax (833) 973-5947
www.TransformationalMedicineSpaTorpey.com

Assignment of Benefits

I, the undersigned, authorize and request that payment of medical benefits be made directly to Transformational Medicine and Spa by Dr. Torpey for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I authorize the release of any medical or other information necessary to process claims related to my treatment. I permit a copy of this authorization to be used in place of the original.

This assignment of benefits will remain in effect until revoked by me in writing. I understand that I am responsible for any balance not paid by my insurance company, including copayments, deductibles, and non-covered services.

Patient Full Name: _____

Date of Birth: _____

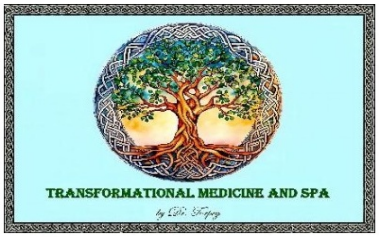
Signature: _____

Date: _____

If not signed by patient:

Name of Authorized Representative: _____

Relationship to Patient / Legal Authority: _____



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Authorization to Release Billing Information

I hereby authorize Transformational Medicine and Spa by Dr. Torpey, its physicians, staff, and billing agents to release any medical or other information necessary to process claims for payment of services provided. This includes the release of:

- Diagnostic and treatment information
- Service dates
- Procedure and diagnosis codes
- Any other information required by my insurance provider, third-party payer, or government benefit program

This authorization allows communication with:

- My health insurance company
- Medicare or Medicaid
- Other third-party payers or guarantors
- Authorized billing or collection services

I understand that:

- This authorization is valid for all services provided by the practice, now and in the future.
- I may revoke this authorization in writing at any time, but such revocation will not affect actions already taken.
- My treatment or eligibility for benefits is not conditional upon signing this form.
- Information disclosed under this authorization may no longer be protected by HIPAA once received by others.

Patient Full Name: _____

Date of Birth: _____

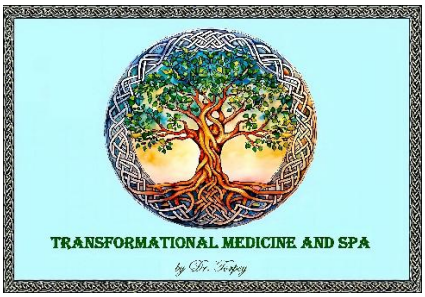
Signature: _____

Date: _____

If not signed by patient:

Name of Authorized Representative: _____

Relationship to Patient / Legal Authority: _____



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Transformational Medicine and Spa by Dr. Torpey
Notice of Privacy Practices

Effective Date: [Insert Date]

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities:

We are required by law to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices.
- Abide by the terms of this notice.
- Notify you in the event of a breach of your unsecured health information.

How We May Use and Disclose Your Health Information:

We may use and share your health information for:

- **Treatment** – To provide, coordinate, or manage your healthcare (e.g., with specialists or pharmacies).
- **Payment** – To bill and collect payment from you.
- **Healthcare Operations** – For administrative, quality assurance, and business management purposes.
- **Appointment Reminders and Follow-Up** – To contact you about appointments or other care-related services.
- **As Required by Law** – To comply with legal obligations (e.g., public health, abuse reporting, law enforcement).
- **Research and Education** – With your written permission or when permitted by law under limited circumstances.

- **Other Disclosures** – With your written authorization, which you may revoke at any time in writing.

Your Rights Regarding Health Information:

You have the right to:

- **Access your medical record** and request copies.
- **Request corrections** to your record if you believe it is inaccurate or incomplete.
- **Request restrictions** on certain uses and disclosures of your information.
- **Request confidential communications**, such as alternative addresses or phone numbers.
- **Receive a list (accounting) of disclosures** we have made of your health information (with some exceptions).
- **File a complaint** if you believe your privacy rights have been violated.

Contact Information:

If you have any questions or would like more information about this notice or to exercise your rights, please contact:

Laurence E. Torpey, M.D.
Transformational Medicine and Spa by Dr. Torpey
1159 Pittsford Victor Road
Suite 160
Pittsford, NY 14534
Phone: (585) 267-7148
Email: TransformationalMedicineandSpa@gmail.com

Patient Acknowledgment and Signature:

By signing below, I acknowledge that I have received and reviewed the Notice of Privacy Practices from Transformational Medicine and Spa by Dr. Torpey.

Patient Name: _____

Date of Birth: _____
Signature: _____
Date: _____

If signed by someone other than the patient, state your legal authority to act on the patient's behalf:

ROCHESTER RHIO

Regional Health Information Organization

Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

Provider Transformational Medicine and Spa by Dr. Torpey

Patient Name	Date of Birth	Patient Identification Number

Patient Address

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, **even** in a medical emergency (except for minor patients).

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used only for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: (585) 267-7148; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.