



New York Division of Military and Naval Affairs
330 Old Niskayuna Road
Latham New York 12110-3514

Received Date
DMNA Use Only

Patient Name: (First, Middle Initial, Last)
Date of Birth:
Social Security Number:
Patient Address: (Including Street, City, State and Zip Code)

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 8(a).
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information, without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the health care provider(s) listed below.
4. 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.
5. 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 8(b).

6. Name and address of health care provider(s) or entity(ies) to release this information:

7. Name and address of person(s) or category of person to whom this information will be sent:
New York Division of Military and Naval Affairs Personal and Confidential 911 Claim 330 Old Niskayuna Rd Latham NY 12110

- 8. (a) Specific information to be released:
Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, 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 to discuss my health information with my attorney or governmental agency listed here:

New York Division of Military and Naval Affairs
(Attorney/Firm Name or Government Agency Name)

9. Reason for release of information:
At the request of individual
Other:
10. This authorization will expire at the completion of the World Trade Center performance of duty disability pension / accidental death benefit application process.
11. If not the patient, name of person signing form:
12. Authority to sign on behalf of patient:

Signature of patient representative authorized by law Date

*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.