



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Telephone #: (____) _____

Date(s) of Treatment: _____

Type(s) of Treatment: _____

This form authorizes the provider to disclose the following specific health information to the recipient

From: _____
(Name/Department/Address of Disclosing Facility of Person)

To: _____
(Name/Department/Address of Facility or Person Receiving the Information)

Information Requested:
 Entire Record Discharge Summary Operative Report Physician's Notes X-Ray
 Face Sheet History & Physical Pathology Report Laboratory

Other: _____

This authorization is granted for the following purpose(s): _____

This authorization is valid until ___/___/___ or until the occurrence of the following event: _____
 _____ Or in any case not to exceed one year.

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations. **However, in the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies:** THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I am signing this authorization voluntarily.

Please Note: There is no charge for records being released to a doctor or hospital. All other requests for records will be charged a fee of \$.75 per page copied.

Only **ONE** of the following sections must be completed.

This section is to be completed if authorization is being given by the Individual :	
_____ Signature of Individual	_____ Date Signed
This section is to be completed if authorization is given by a Personal Representative :	
_____ Name of Personal Representative:	_____ Signature of Personal Representative
_____ Date Signed	_____ Description of Authority to act as personal Representative of the Individual (e.g., Guardian, Attorney, Health Care Agent)



New York State Department of Health AIDS Institute

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing a written release or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive. State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally disclosed HIV related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time by indicating your change in writing. Upon your request, the facility of provider asking for this release must provide you with a copy of this form as signed by you or left unsigned.

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212)480-2493 or the New York City Commission of Human Rights at (212)306-5070. These agencies are responsible for protecting your rights.

Form with fields: Name and address of facility/provider obtaining release; Name of person whose HIV related information will be released; Name(s) and address(es) of person(s) signing this form; Relationship to person whose HIV information will be released; Name(s) and address(es) of person(s) who will be given HIV related information; Reason for release of HIV related information; Time during which release is authorized (From: To:).

The Facility Provider obtaining this release must complete the following:

Form with fields: Exceptions, if any, to the right to revoke consent for disclosure; Description of the consequences if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits; (Note: Federal privacy regulations may restrict some consequences.); My Questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time and revoke my authorization by writing the facility/provider obtaining this release; Date; Signature.