Authorization for Release of Protected Health Information (including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS- related information

Patient Name:	Date of Birth:	Patient ID #
Patient Address:		

1. I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that this authorization may include disclosure of: Information relating to Alcohol/Drug Treatment and Mental Health Treatment, unless I restrict the release of this information in Item 9; and Confidential HIV/AIDS- related information only if I place my initials on the appropriate line in Item 9. I specifically authorize the release of such information to Person(s)/Entity indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under applicable federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization any time by writing to the provider/entity listed below in Item 5, except to the extent that action has already been taken based on this authorization. I have the right to inspect/receive copy of the information to be released.
4. Signing this authorization is voluntary. I understand that my treatment, payment, enrollment in health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider/Entity to **RELEASE** this information:

6. Name and Address of Person(s)/Entity to **RECEIVE** this information:

7. Purpose for release of information: ☐ At my request ☐ Continuity of Care/Treatment ☐ Other: _____

8. Authorization expiration date or event: _____ (if expiration date/event is not specified, this authorization will expire when the above named person/entity, authorized to receive this information, is no longer involved in the patient's care).

9. Information to be released: _____

☐ Any and All Protected Health Information (written or oral), except: _____
I authorize the disclosure of the following Sensitive Health information if the requested portion of my record contains it: Behavioral and Mental Health Services, Treatment for Alcohol and Drug abuse, STD (Sexually transmitted diseases), genetic testing (including test results). I have the right to restrict the release of my Sensitive health information listed above (indicate restrictions here, if any): _____

By placing my initials bellow, I authorize the disclosure to include the following Sensitive health information:
_____ HIV/AIDS related information

I have read the above information and all my questions about this form have been answered. By signing below, I acknowledge that I accept all of the above. All items on this form have been completed and I have been provided a copy of this form.

☒ _____ _____
Signature of Patient/Parent/Legal Guardian/Personal Representative **Date**

_____ _____
If not the patient, Print Name of person signing this authorization **Authority to sign on patient's behalf**

*Witness's signature is only required if the patient has the capacity to consent but physically unable to sign his /her name (e.g.., signature is a mark).

Witness*: _____ _____ _____
Signature Print Name/Title Date