Sample Form

New York State Department of Health

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV and NON-HIV Related Information

EVERYONE, REGARDLESS OF DIAGNOSIS OR MEDICAL CONDITION, MUST SIGN THIS HIPAA

I consent to disclosure of: ☐ My HIV Medical Information* ☐ My **NON**-HIV Medical Information** ✓ Check the appropriate box

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses 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 medical and/or HIV-related 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; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

Information in the box below must be completed

Name and address of facility/person disclosing HIV-related and/or medical information:

Doctor's Name: - - - Your doctor's name here - - -

Medical Facility/Hospital: - - - Name / address of medical facility you attend - - -

Agency: God's Love We Deliver

Name of person whose information will be released: - - - Your name here - - -

Name and address of person signing this form (if other than above): _____

Relationship to person whose information will be released: _____

Describe information to be released: _____

Reason for release of information: Home-delivered meals

Time period during which release of information is authorized. From: _____ To: _____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any: _____

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):

_____

All facilities/persons listed on pages 1 and 2 of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize:

Signature: - - - Your signature here - - - **Date:** Date you sign the document

*Human Immunodeficiency Virus that causes AIDS ** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Please complete the information on P.2

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Provide information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

God's Love We Deliver

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify: List your organization here

Name and address of facility/person to be given general medical and/or HIV-related information:

Include the name(s) of anyone who may reach us regarding your home-delivered meal services. Examples: Social Worker, Case Manager, family member or friend. Add their relationship to you and a contact phone number and address.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

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) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature: - - - Your signature here - - - **Date:** Date you sign the document

(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____