

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

Complete 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:

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 _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

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POUGHKEEPSIE NY 12601

P: 845.483.0500 F: 845-483-0537