Family Planning
OF SOUTH CENTRAL NEW YORK, INC.™

Binghamton	117 Hawley Street, Binghamton, NY 13901	(607) 723-8306	Fax (607) 217-4139
Oneonta	37 Dietz Street, Oneonta, NY 13820	(607) 432-2250	Fax (607) 432-2984
Norwich	5 Cortland Street, Norwich, NY 13815	(607) 334-6378	Fax (607) 336-1304
Cortland	165 Main Street, Cortland, NY 13045	(607) 250-9004	Fax (607) 543-4290
Sidney	37 Pleasant Street, Sidney, NY 13838	(607) 432-2250	Fax (607) 432-2984
Walton	130 North Street, Walton, NY 13856	(607) 432-2250	Fax (607) 432-2984

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state laws. 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 New York 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 health 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 more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

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

I consent to the disclosure of (please check all that apply):

- ◯ My HIV-related health information
- ◯ My non-HIV health information
- ◯ Both (non-HIV and HIV-related health information)

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

Phone: Fax:

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

Name and date of birth of person whose information will be released:

Relationship to person whose information will be released:

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Information to be released:

- ☐ History & Physical
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Pap Smear/Abnormal Pap
- ☐ Progress Notes
- ☐ Colposcopy/LEEP records
- ☐ Pelvic Ultrasound
- ☐ Mammogram/Breast US
- ☐ Entire Medical Record
- ☐ Referral Follow Up Records
- ☐ Other (Describe):

Reason for release of information:

- ☐ Personal Use
- ☐ Continuity of Medical Care
- ☐ Transferring to Another Provider
- ☐ Other (Describe):

Time Period During Which Release of Information is Authorized:

From: To:

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):

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that you enter N/A or cross out blank lines prior to signing.

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

Phone: Fax:

Reason for release, if other than stated above:

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

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

Phone: Fax:

Reason for release, if other than stated above:

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

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This law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health 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 1 to release health and/or HIV-related information of the person named on page 1 to the organizations/persons listed.

Please sign below only if you wish to authorize all facilities/persons listed on pages 1 and 2 of this form to share information among and between themselves for the purpose of providing health care and services.

Signature: Date:

☐ I have been offered a copy of this release form.

Signature: Date:

If legal representative, indicate relationship to subject:

Print Name: Client/Patient MRN:

Signature of Witness: Date:

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