Authorization for the Release of Health Information

Your health information is personal and we are committed to protecting the privacy of that information. We must therefore obtain your written authorization before we disclose your health information for the purposes described below. This form provides that authorization and clarifies for us how you want your personal health information to be disclosed.

Please print clearly and read everything carefully before signing this form. Forms can be turned into Primary Care Medical Services in John Jay Hall, or can be faxed to 212-854-0673.

Patient name___________________________________
Date of birth_________________________
Address____________________________________
City __________________ State______________ Zip Code__________________
Telephone__________________________________

I, or my authorized representative, request that my health information regarding my care and treatment at Health Services at Columbia or at _______________________________ be released to the party named below.

Release to:
Name of person or organization____
Address____
Telephone______________________________ Fax_____________________________________
☐mail ☐fax ☐patient pickup ☐mail to patient

Information to be released:
Specific Treatment dates____
☐complete medical record ☐allergy ☐immunizations
☐lab results specifically__________________________________ ☐all
☐radiology results specifically_____________________________ ☐all
☐HIV/AIDS diagnosis, treatment, discussion__________(initial see reverse side)
☐other____

Reason for disclosure:
☐further medical care ☐payment of insurance claim ☐legal investigation
☐personal ☐academic accommodation
☐other

Date or event that will trigger the expiration of this authorization:
☐one time only ☐3 months ☐6 months ☐ one year ☐other_____________________________

I understand that I may withdraw this consent at any time except insofar as action has already been taken in reliance thereupon. A facsimile of this form will be regarded as valid as an original. I understand that I must revoke this authorization in writing.

I have read and understand the information in this authorization form.

Signature____
Date______________________

For staff use only
Processed by________________________ Date________________
Comments____

Regarding the release of HIV-related information. *Confidential HIV-related information is any information indicating that a person had an HIV test, has potentially been exposed to HIV, has HIV infection, or has an HIV/AIDS-related illness. Under New York State Law, confidential HIV-related information can only be provided 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; jail, prison, probation, parole employees; emergency response workers, who are exposed to blood/body fluids in the course of their employment; organizations that have the authority to review the services that you receive (e.g. accreditation agencies, the Department of Health). State law also allows your HIV information to be released under specific and limited circumstances: by special court order; to public health officials; to insurers as necessary to pay for care and treatment. Under state law, anyone who illegally discloses HIV-related information may be punished by a fine and jail term of up to one year. For more information about HIV confidentiality, you may call the NY State Department of Health HIV Confidentiality Hotline at* ***(800) 962-5065.***

If you sign the request for release of HIV-related information, this information can only be given to people and for the reasons listed on the form. ***You do not have to sign this form, and you can change your mind at any time by indicating your change in writing.*** *Upon your request, the facility or provider to whom your HIV-related information was provided must release to you 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 ***(800) 523-2437*** *or the New York City Commission of Human Rights at* ***(212) 306-5070.***