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**PHYSICIAN PRACTICE**

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

**(NOTE: THIS FORM CANNOT BE USED TO AUTHORIZE A RELEASE OF HIV-RELATED INFORMATION)**

**PATIENT NAME:** \_\_\_\_\_  
  LAST  FIRST  MIDDLE

**HOME ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**PREFERRED TELEPHONE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**SPECIFY INFORMATION TO BE DISCLOSED:** \_\_\_\_\_  
\_\_\_\_\_

**RECIPIENT:** NAME OF THE PERSON OR CLASS OF PERSONS TO WHOM THE PRACTICE MAY DISCLOSE MY HEALTH INFORMATION:  
\_\_\_\_\_

**ADDRESS OF RECIPIENT OR WHERE MY HEALTH INFORMATION SHOULD BE DELIVERED:**  
\_\_\_\_\_  
\_\_\_\_\_

**OR**

**FAX NUMBER WHERE MY HEALTH INFORMATION SHOULD BE DELIVERED:** \_\_\_\_\_

**TERM: THIS AUTHORIZATION WILL REMAIN IN EFFECT:**

- FROM THE DATE OF THIS AUTHORIZATION UNTIL THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_.
- UNTIL THE FOLLOWING EVENT OCCURS: \_\_\_\_\_
- OTHER: \_\_\_\_\_

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s)-“At the request of the patient” is sufficient if the patient is initiating this Authorization:

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I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice’s treatment of me: except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the Term of the Authorization expires of I provide a written notice or revocation to the Practice Office Manager at the address listed below. The revocation will be effective immediately upon the practice’s receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this authorization before it received my written notice of revocation.

The address of the Practice’s Office Manager is **71 Park Avenue, Suite 1A, New York, N.Y. 10016**. And I may contact the Office Manager by telephone at **212-689-9587**.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DESCRIPTION OF AUTHORITY

\_\_\_\_\_  
DATE

**IF THE PRACTICE HAS REQUESTED THIS AUTHORIZATION, PLEASE PROVIDE A COPY OF THE SIGNED AUTHORIZATION TO THE PATIENT**

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV\* RELATED INFORMATION

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

**Name of person whose HIV related information will be released:**

\_\_\_\_\_

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

\_\_\_\_\_

**Relationship to person whose HIV Information will be released:**

\_\_\_\_\_

\_\_\_\_\_

**Name and address of person who will be given HIV related information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reasons for release of HIV related information:**

\_\_\_\_\_

\_\_\_\_\_

**Time during which release is authorized:**

From: \_\_\_\_\_ To: \_\_\_\_\_

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature