



**Authorization for Release of
Confidential HIV* Related Information-
Case Management Programs**

New York State Department of Health AIDS Institute

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, confidential HIV related information can only be given 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; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive. The law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. 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.

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.

The law protects you from HIV related discrimination in housing, employment, health care or 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) 417-5043 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

PLEASE DO NOT FILL IN SHADED SECTIONS.

Name and address of facility/provider obtaining release:	
REVERSE	
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:	
SEE REVERSE	
Reason for release of HIV related information:	
To provide appropriate medical and case management services.	
Extent or nature of information to be released:	Medical and case management assessment Psycho-social treatment plans Progress notes and other related information as required
Time during which release is authorized:	From: _____ To: _____
Signature of person authorized to consent to the release of confidential HIV related information:	

* Human Immunodeficiency Virus that causes AIDS.

** Federal regulations regarding alcohol and drug abuse patient records (42 CFR Part 2) require your consent or a court order for release of drug and alcohol related information even when New York State Law does not.

Please Complete Information on Reverse Side.

NEW YORK STATE APPROVED FORM MEETS STATE AND FEDERAL (42 CFR Part 2) CONSENT FORM REQUIREMENTS

Authorization for Release of Confidential HIV Related Information — Case Management Programs

I authorize _____
(Provider name and address)

to release the records of the person named on the reverse, including HIV related information, to the agencies listed below. I also authorize the agencies listed below to release such records back to the named providers and to share necessary HIV related information among between themselves for the purpose of providing assistance in receiving needed services. I understand that these records, including the HIV related information, cannot be shared by these agencies with persons or organizations not named or identified on this release and that I can withdraw my consent to this release agreement at any time.

Note: Unused boxes MUST be crossed out prior to authorizing signature.

Agency name:	Agency name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

Agency name:	Agency name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

Agency name:	Agency name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

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.

Signature _____

Date: ____/____/____

Signature of parent
or guardian if required: _____

Date: ____/____/____