State University of New York
Upstate Medical University

University Hospital
750 East Adams Street • Syracuse NY 13210

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND CONFIDENTIAL HIV* – RELATED INFORMATION

This form authorizes the disclosure of protected health information, which **may** include 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 an authorization form.

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

If you experience discrimination because of release of HIV information, you may contact the New York State Division of Human Rights at (315) 428-4633 or 1-800-523-AIDS (2437). This agency is responsible for protecting your rights.

This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal or state law. If you are authorizing the release of HIV-related information, you should be aware that the recipient is prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law.

If you refuse to sign this authorization, your health care, payment for your health care, and your health care benefits will not be affected. You have the right to revoke this authorization at any time by writing to the University Hospital Director of Clinical Data Services.

Name and address of facility disclosing protected health information:

Name of person/patient whose medical and/or HIV-related information will be disclosed:

Person signing this form (if other than patient):
Name: Relationship to patient:
Address: Phone Number:

Person/agency who will be given medical and/or HIV-related information: (additional space on the back)
Name: Phone Number:
Address:

Reason for disclosure:
☐ Coordination of care ☐ Legal proceedings
☐ Patient request ☐ Other: ____________

Specify information to be disclosed: ____________
Including HIV-related Information ☐ Yes ☐ No

Authorization expires on: ____________
☐ Revocation ☐ Specific date or event: ____________

My questions about this form have been answered. I know that I do not have to allow release of medical and/or HIV- related information.

Signature ____________ Date ____________

Name of Witness** ____________ Patient's Date of Birth ____________

Signature of Witness** ____________ Patient's Telephone Number ____________

*Human Immunodeficiency Virus that causes AIDS
**Required for Psychiatric Records Only

Agency or Individual Name and Relationship:	Agency or Individual Name and Relationship:
Address	Address
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:

Agency or Individual Name and Relationship:	Agency or Individual Name and Relationship:
Address	Address
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:

Agency or Individual Name and Relationship:	Agency or Individual Name and Relationship:
Address	Address
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number: