ROME HEALTH

1500 North James Street, Rome, New York 13440

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Including Alcohol/Drug Treatment and Mental Health Information) AND CONFIDENTIAL HIV/AIDS RELATED INFORMATION

Patient Name:	Date of Birth:	Phone:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL, DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event that the health information described below includes any of these types of information, and I initial the line on the box in item 8, I specifically authorize release of information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at anytime by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed: Fax:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed for 1 year or until: _____
Insert Expiration Date/Event

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and check below.	**Information to be Disclosed**	
☐ Records from alcohol/drug treatment programs		☐ Accept ☐ Decline
☐ Clinical records from mental health programs		☐ Accept ☐ Decline
☐ HIV/AIDS-related Information		☐ Accept ☐ Decline

9. Authority to sign on behalf of patient:

The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 (where parent or guardian must sign) or otherwise lacks capacity to sign (where health care agent, next of kin or legal guardian must sign).

Print Name _____ Relationship _____ Patient/Authorized Representative Signature _____ Date/Time _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND CONFIDENTIAL HIV/AIDS RELATED INFORMATION

4HROI