



Authorization to Disclose Protected Health Information

1. I authorize: [ ] Gannett Health Services - OR - [ ] Other: \_\_\_\_\_

2. To disclose the protected health information of:

Patient Name \_\_\_\_\_ CU ID# \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_
Zip Code \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

3. To the following individual or organization:

Name of person or organization \_\_\_\_\_
Address \_\_\_\_\_
Phone \_\_\_\_\_ FAX \_\_\_\_\_

4. Purpose of the disclosure:

- [ ] further health care [ ] payment of insurance claim [ ] legal investigation [ ] further mental health evaluation or treatment
[ ] academic accommodations [ ] health leave of absence coordination [ ] personal use [ ] coordination of services with friends/ family
[ ] other \_\_\_\_\_

5. Information to be disclosed:

- ➔ Treatment dates \_\_\_\_\_
[ ] clinic note(s) [ ] x-ray films [ ] minimum information needed to coordinate a health leave of absence
[ ] immunizations [ ] billing records [ ] summary of mental health evaluation and treatment \_\_\_\_\_ (must initial)
[ ] physical therapy note(s) [ ] sports medicine note(s) [ ] mental health medication treatment history \_\_\_\_\_(must initial)
[ ] radiology report(s) [ ] pathology report(s) [ ] other \_\_\_\_\_
[ ] lab report(s) [ ] HIV/AIDS diagnosis, treatment, testing, or discussion \_\_\_\_\_ (initial, see reverse side)
[ ] health information that might impact, or be impacted by, my employment at Cornell University

6. I understand that:

- I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
I may refuse to sign this authorization. Gannett Health Services will not restrict in any way treatment, payment, enrollment in a health plan, or eligibility for benefits by refusing to sign this authorization.
A fee may be charged for copying the protected health information.
Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
Unless otherwise revoked, this authorization will expire on (date or event) \_\_\_\_\_. If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

FOR GANNETT USE ONLY

Action to be taken on receipt of this form:

- [ ] None now - file in chart [ ] Copy and send [ ] Verbal/Phone disclose only [ ] Obtain records indicated

Records were: discussed faxed mailed picked up on \_\_\_\_/\_\_\_\_/\_\_\_\_ Initials \_\_\_\_\_

## Regarding The Release Of 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 that 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; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals or 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. State 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. Under State law, 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. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 800.962.5065.

If in item #5 on the previous page, you check and initial "HIV/AIDS diagnosis, treatment, testing, or discussion," 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 by indicating your change in writing. Upon your request, Gannett Health Services must provide you with 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 212.480.2493, or the New York City Commission of Human Rights at 212.306.5070. These agencies are responsible for protecting your rights.