Potsdam
The State University of New York

OBTAINING RECORDS

AUTHORIZATION FOR RELEASE OF MEDICAL
RECORDS AND INFORMATION

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. 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 medical and/or HIV-related 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 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

I consent to disclosure of (Indicate by initialing):

_____My non-HIV medical information (may include sexual health)
_____Both (non-HIV medical and HIV-related information)
_____Alcohol/Drug Treatment
_____Mental Health Information

TO: PRIVATE HEALTH CARE CLINIC

Name: _____

Address: _____

Phone/Fax Number: _____

I hereby authorize the release of my medical records to:

_____ (name of provider)

The specific information needed:

____ Medical record from (insert date) _____to (insert date)_____
____ History and Physical (most recent)
____ Immunization records and PPD results
____ PAP smear lab report
____ Other (please specify) _____

Print name: _____ Date of Birth: _____ Telephone: _____

_____ _____ _____
Signature of patient Date S.S. #

Revised: 3/95, 12/98, 2/04, 1/05, 12/05, 1/07, 8/07

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