WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
Cedarwood Hall
Valhalla, NY 10595-1689

NAME _____

ADDRESS _____

CITY _____ **STATE**_____ **ZIP** _____

D.O.B. _____ **WIHD#** _____

AUTHORIZATION TO DISCLOSE and/or EXCHANGE PROTECTED HEALTH INFORMATION

I authorize Westchester Institute for Human Development to **disclose and/or exchange** the above-named individual's health information as follows. (Check the appropriate boxes):

☐ Entire Record ☐ Other (Please describe)_____

Include (by initialing – if applicable): ____ HIV-Related Information and test results

____ Alcohol/Drug Treatment ____ Mental Health Treatment (Except Psychotherapy Notes)

The information above may be disclosed to the following:

Name/Organization:_____ **Phone:**_____ **Fax:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email (if applicable):_____

By initialing here _____ I authorize _____ to:
(Initials) **(Name of Individual health care provider)**

☐ **Discuss my health information with the above named Individual or Organization**
☐ **Disclose paper records to the above named Individual or Organization**

This information for which I'm authorizing disclosure will be used for the following purposes.

☐ My personal records ☐ Sharing with other healthcare providers as needed
☐ Sharing with school personnel including teachers and related service providers
☐ Other (please describe): _____

TO BE READ AND SIGNED BY PATIENT:

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This will only be included if I place my initials in the appropriate box above.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I understand that I have a right to revoke this authorization at any time by providing written notice to the practice, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it..
4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I have the right to refuse to sign this form and that I need not sign this form to ensure healthcare treatment, payment for my healthcare, or continuation of my healthcare benefits.
6. I understand that WIHD has the right to charge a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill my request.
7. I understand that I have the right to inspect or copy information to be used or disclosed as described in this form and in accordance with Institute policies and procedures. I have the right to receive a copy of this form after I have signed it.
8. I acknowledge that I have had the opportunity to review this authorization and understand the intent and use. My questions about the form have been answered to my satisfaction.

Signature of Patient or Personal Representative	**Print Name of Patient or Personal Representative**
Description of Personal Representative's Authority	**Date**