W	Westchester Institute
HD	for Human Development

AUTHORIZATION TO DISCLOSE and/or
EXCHANGE PROTECTED HEALTH
INFORMATION

NAME		
ADDRESS		
CITY	STATE	ZIP
D.O.B	WIHD#	

11 (1 011/1111101)							
I authorize Westchester Institute for Human E information as follows. (Check the appropriat		and/or exchange the abo	ove-named individual's health				
☐ Entire Record ☐ Other (Please describe)							
Include (by initialing – if applicable):	_ HIV-Related Inform	ation and test results	Alcohol/Drug Treatment				
The information above may be disclosed to th	e following:						
Name or Organization:		Phone:	Fax:				
Address:	City:	State:	Zip:				
Email (if applicable):							
I authorize Westchester Institute for	Human Development t	o (please check all that a	apply below):				
	 □ Discuss my health information with the above named Individual or Organization □ Disclose medical records to the above named Individual or Organization 						
This information for which I'm authorizing di	sclosure will be used for	r the following purposes.					
☐ My personal records ☐ Sharing with school personnel inclu ☐ Other (please describe):	iding teachers and relate	d service providers					
TO BE READ AND SIGNED BY PATIENT	:						
TO BE READ AND SIGNED BY PATIENT I understand that the information in my health recosyndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be included.	rd may include information re rus (HIV). It may also includ	e information about behavioral					
I understand that the information in my health reco syndrome (AIDS), or human immunodeficiency vir	rd may include information re rus (HIV). It may also includ ded if I place my initials in th hol, or drug treatment, or men ation unless permitted to do so	e information about behavioral te appropriate box above. ntal health treatment information to under federal or state law. I u	or mental health services, and treatment in, the recipient is prohibited from				
I understand that the information in my health reco syndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be inclu If I am authorizing the release of HIV-related, alco redisclosing such information without my authorized.	rd may include information regres (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mentation unless permitted to do so lated information without authorization at any time by provide	e information about behavioral as appropriate box above. Intal health treatment information ounder federal or state law. I without the contraction.	or mental health services, and treatment on, the recipient is prohibited from understand that I have the right to request				
I understand that the information in my health reco syndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be inclu If I am authorizing the release of HIV-related, alco redisclosing such information without my authorized a list of people who may receive or use my HIV-re I understand that I have a right to revoke this authorized.	rd may include information re rus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mer ation unless permitted to do so lated information without auti- rization at any time by provice y acted in reliance on it	e information about behavioral are appropriate box above. Intal health treatment information of under federal or state law. Inthorization. It written notice to the praction	or mental health services, and treatment in, the recipient is prohibited from inderstand that I have the right to request ce, except to the extent that the program				
I understand that the information in my health reco syndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be inclu If I am authorizing the release of HIV-related, alco redisclosing such information without my authoriza a list of people who may receive or use my HIV-re I understand that I have a right to revoke this author or person who is to make the disclosure has already I understand that once the above information is discrete.	rd may include information rerus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mereation unless permitted to do so lated information without authorization at any time by provide acted in reliance on it	e information about behavioral are appropriate box above. Intal health treatment information of under federal or state law. I underization. It is written notice to the practical by the recipient and the information. It is written to the practical by the recipient and the information.	or mental health services, and treatment in, the recipient is prohibited from inderstand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution in the right to refuse to sign				
I understand that the information in my health reco syndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be inclu If I am authorizing the release of HIV-related, alco redisclosing such information without my authoriza a list of people who may receive or use my HIV-re I understand that I have a right to revoke this author or person who is to make the disclosure has already I understand that once the above information is disciprivacy laws or regulations. I understand that authorizing the use or disclosure of	rd may include information rerus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or meration unless permitted to do so lated information without autivation at any time by provice acted in reliance on it	e information about behavioral are appropriate box above. Intal health treatment information of under federal or state law. It is horization. It will be the practice of the practice by the recipient and the information in the practice of the practice o	or mental health services, and treatment in, the recipient is prohibited from inderstand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution of my healthcare benefits.				
I understand that the information in my health reconsyndrome (AIDS), or human immunodeficiency virior alcohol and drug abuse. This will only be inclused. If I am authorizing the release of HIV-related, alconedisclosing such information without my authorizated list of people who may receive or use my HIV-results. I understand that I have a right to revoke this author or person who is to make the disclosure has already all understand that once the above information is disciprivacy laws or regulations. I understand that authorizing the use or disclosure of this form and that I need not sign this form to ensure	rd may include information rerus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or meration unless permitted to do so lated information without autivated in reliance on it closed, it may be redisclosed of the information identified a re healthcare treatment, paymerasonable fee to recover the continuous information to be used or discovering the information to the used or discovering the information the used or discovering the information the information the used or discovering the information the used or discovering the used the information the used the used to the used the used the used to the used the used the used to the used to the used the used to the used the used to the used the used the used to the	e information about behavioral are appropriate box above. Intal health treatment information of under federal or state law. I underization. It will be the recipient and the information of the recipient and the information of the practical devices and the information of the practical devices are continuously of the practical devices and the information of the practical devices are continuously of the practical devices and the information of the practical devices are continuously of the practical devices and the practical devices are continuously of the practical devices and the practical devices are continuously of the practical devices are continuous	or mental health services, and treatment in, the recipient is prohibited from understand that I have the right to request ce, except to the extent that the program ation may not be protected by federal d that I have the right to refuse to sign mustion of my healthcare benefits.				
 I understand that the information in my health recosyndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be inclused. If I am authorizing the release of HIV-related, alcoredisclosing such information without my authorization a list of people who may receive or use my HIV-resolution. I understand that I have a right to revoke this authoror person who is to make the disclosure has already already laws or regulations. I understand that authorizing the use or disclosure of this form and that I need not sign this form to ensure the laws of t	rd may include information re rus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mer ation unless permitted to do so lated information without authorization at any time by provide acted in reliance on it closed, it may be redisclosed for the information identified a re healthcare treatment, paymeasonable fee to recover the continuous action to be used or distance of this formation to be used or distance of this form after I had	e information about behavioral as appropriate box above. Intal health treatment information of under federal or state law. It is horization. It will be the practice of the	or mental health services, and treatment in, the recipient is prohibited from inderstand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution of my healthcare benefits. In applies used to fulfill my request.				
 I understand that the information in my health recosyndrome (AIDS), or human immunodeficiency vir for alcohol and drug abuse. This will only be included a list of people who may receive or use my HIV-related, alcoor precision information without my authorized a list of people who may receive or use my HIV-related. I understand that I have a right to revoke this author or person who is to make the disclosure has already already laws or regulations. I understand that authorizing the use or disclosure of this form and that I need not sign this form to ensure this form and that WIHD has the right to charge a relation of the policies and procedures. I have the right to receive a I acknowledge that I have had the opportunity to relation to the support of the policies and procedures. I have the opportunity to relation to the support of the policies and procedures. I have the opportunity to relation to the support of the policies and procedures. 	rd may include information re rus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mer ation unless permitted to do so lated information without autivacted in reliance on it closed, it may be redisclosed of the information identified a re healthcare treatment, payme assonable fee to recover the company information to be used or discayed a copy of this form after I has eview this authorization and universe.	e information about behavioral as appropriate box above. Intal health treatment information of under federal or state law. It is horization. It will be the practice of the	or mental health services, and treatment in, the recipient is prohibited from understand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution of my healthcare benefits. In pipelies used to fulfill my request. In and in accordance with Institute in My questions about the form have been				
 I understand that the information in my health reconsyndrome (AIDS), or human immunodeficiency virior alcohol and drug abuse. This will only be included alcohol and drug abuse. This will only be included alcohological such information without my authorized a list of people who may receive or use my HIV-reduced. I understand that I have a right to revoke this authoror person who is to make the disclosure has already always or regulations. I understand that once the above information is disciprivacy laws or regulations. I understand that authorizing the use or disclosured this form and that I need not sign this form to ensure this form and that WIHD has the right to charge a reduced are reduced. I understand that I have the right to inspect or copy policies and procedures. I have the right to receive answered to my satisfaction. Signature of Patient or Personal Representative 	rd may include information re rus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mer ation unless permitted to do so lated information without autivacted in reliance on it closed, it may be redisclosed of the information identified a re healthcare treatment, paym easonable fee to recover the company of this form after I has eview this authorization and under the print National Control of the information to be used or discussed in the property of the information to be used or discussed in the property of the information to be used or discussed in the property of the propert	e information about behavioral and appropriate box above. Intal health treatment information of under federal or state law. It is horization. It is written notice to the practice by the recipient and the information above is voluntary. I understangent for my healthcare, or continuous of copying, mailing, and successed as described in this form we signed it. Inderstand the intent and use. In the of Patient or Personal in the proposition of the practice of	or mental health services, and treatment in, the recipient is prohibited from understand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution of my healthcare benefits. In and in accordance with Institute in and in accordance with Institute in the service of the services in the services about the form have been in the services and the services and the services in the service				
 I understand that the information in my health reconsyndrome (AIDS), or human immunodeficiency virior alcohol and drug abuse. This will only be included alcohol and drug abuse. This will only be included alcohological such information without my authorized a list of people who may receive or use my HIV-reduced. I understand that I have a right to revoke this authoror person who is to make the disclosure has already always or regulations. I understand that once the above information is disciprivacy laws or regulations. I understand that authorizing the use or disclosured this form and that I need not sign this form to ensure this form and that WIHD has the right to charge a reduced are the right to inspect or copy policies and procedures. I have the right to receive answered to my satisfaction. 	rd may include information re rus (HIV). It may also includ ded if I place my initials in the hol, or drug treatment, or mer ation unless permitted to do so lated information without autivacted in reliance on it closed, it may be redisclosed of the information identified a re healthcare treatment, paym easonable fee to recover the company of this form after I has eview this authorization and under the print National Control of the information to be used or discussed in the property of the information to be used or discussed in the property of the information to be used or discussed in the property of the propert	e information about behavioral are appropriate box above. Intal health treatment information of under federal or state law. It is horization. It was a state in the practical of the practical	or mental health services, and treatment in, the recipient is prohibited from understand that I have the right to request ice, except to the extent that the program ation may not be protected by federal individual distribution of my healthcare benefits. In and in accordance with Institute in and in accordance with Institute in the service of the services in the services about the form have been in the services and the services and the services in the service				