CALLEN-LORDE HEALTH INFORMATION RELEASE FORM #:_____

Section 1: Patient Information

Last name:	First Name:		Today's date: / /
Address:		Apartment #:	Date of Birth: / /
City:	State:	Zip Code:	Phone number: ( )

Section 2: Release Information To

I hereby authorize Callen-Lorde Community Health Center to share my individually identifiable health information, which may include protected or privileged information form to the below listed person/organization.

Name:	Organization and Department:		
Address:			Phone number: ( )
City:	State:	Zip Code:	Fax number: ( )

Section 3: Information to be Disclosed

Please check how the information should be initially released: ☐ Fax ☐ Mail ☐ Pick-up ☐ Verbal/3rd party communication

Medical Records: Please check **Yes** or **No** for each of the following types of records:

Yes	No	
☐	☐	My records for medical treatment during the following time period _____ to _____.
☐	☐	Most recent laboratory results
☐	☐	All laboratory results
☐	☐	All medical records
☐	☐	Other records: _____

Dental Records: Please check **Yes** or **No** type of record to be released and from which time period:

_____ to _____.

Yes	No	
☐	☐	Dental - Radiographs
☐	☐	Dental - Treatment Plan
☐	☐	Dental - Progress Notes
☐	☐	All dental records
☐	☐	Other: _____

Release is to exclude the following information: _____

Section 4: Sensitive Information

The following categories of information will **NOT** be released from your records without your specific authorization. To authorize release, **sign your complete name** next to the categories you want released.

	Information to be Disclosed	**Patient Signature**
HIV Related Information (Including HIV Testing)		
Mental Health Treatment		
Substance Use & Treatment (Including alcohol/drug)		

Section 5: Release Reason & Time Frame

Reason: I authorize release of information for the following reason:

Time Frame: Please specify the date of expiration if different than 12 months. / /

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:

This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my signature on the appropriate line section 4 of this form. In the event the health information described above includes any of these types of information, and I signed the line in the Sensitive Information section, I specifically authorize release of such information to the person(s) indicated in section 2.

With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDSrelated, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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/AIDSrelated information, I may contact the New York State Division of Human Rights at 18883923644. This agency is responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to Callen-Lorde Community Health Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

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.

X _____ _____/_____/_____

Patient Signature **Date**

This authorization expires 12 months from the date it was signed unless otherwise specified in Section 5.

For Staff Use Only:	Processed: Date: _____
Date: _____	By: _____
Staff Witness: _____	Sent via: _____