INDIVIDUAL AUTHORIZATION FOR THE EXCHANGE, USE AND DISCLOSURE OF PROTECTED HIV-RELATED HEALTH INFORMATION

Consumer Name: _____ Consumer Date of Birth: _____

WNYIL, Inc. understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we use or disclose your protected health information for the purposes described below. This form provides that authorization and helps make sure that you are properly informed of how this information will be used or disclosed. Please read and complete the information below carefully before signing this form.

This form authorizes the specific release of **HIV-related health information**. 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.

I, or my authorized representative, hereby authorize the use or disclosure of protected HIV-related health information as follows:

___One-Way, information shared by Person/Organization #1 to WNYIL, Inc (#2)
___Two-Way, information shared **between both** Person/Organization #1 **and** WNYIL, Inc (#2)

# 1 Person/Organization:_____		**# 2 WNYIL, Inc.**	
Name		**Staff Name**	
Title		**Staff Title**	
Address		**Address**	
Phone		**Phone**	___-___-___ ext. ____
Fax		**Fax**	

_____ Initial if all records may be shared.

If you do not want all records shared, please indicate what specific records can be shared:

_____
_____
_____
_____

The purpose of this disclosure is to provide and/or facilitate coordination of health service activities for the above named consumer.

Expiration Date: _____

Specific Understandings:

- By signing this authorization form, I authorize the exchange, use or disclosure of my HIV-related health information protected by the federal health privacy law 45 CFR parts 160, 164, as described above.
- I understand that under New York State Law, HIV-related information can only be given to people I 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 New York 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 redisclosures of health and/or HIV-related information are not protected under federal law. I have the right to request a list of people who may receive or use my HIV-related health information without authorization. For more information about HIV confidentiality, I can call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.
- I understand the law protects me from HIV-related discrimination in housing, employment, health care and other services. For more information or to report any form of discrimination as a result of the release or disclosure of HIV-related information, I can call the NYS Division of Human Rights at 1-888-392-3644.
- I understand that I do not have to allow release of my HIV-related health information, and that I can change my mind and revoke my authorization at any time, except to the extent that WNYIL, Inc. has already taken action based upon your authorization. To revoke this authorization, please write to WNYIL, Inc. Intake Office, 3108 Main Street, Buffalo, New York 14214.

SIGNATURE: *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

_____ _____

Print Name of Consumer or Authorized Representative (Representative Date of Birth, if applicable)

_____ _____

Signature of Consumer or Authorized Representative Date

Description of Authorized Representative's Authority (if applicable): _____

_____

THE CONSUMER OR HIS/HER AUTHORIZED REPRESENTATIVEHAS THE RIGHT TO BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.