# MOUNT VERNON NEIGHBORHOOD HEALTH CENTER INC.

## AUTHORIZATION FOR RELEASE OF HEALTH AND CONFIDENTIAL HIV-RELATED INFORMATION

☐Mount Vernon Neighborhood Health Center ☐Yonkers Community Health Center ☐Greenburgh Health Center

☐Grasslands Homeless Shelter ☐The Coachman Family Center ☐Women's Premier Obstetrics

☐School Based Health Center/Williams Elementary School ☐School Based Health Center/Mount Vernon High School

| Patient Name | Patient Date of Birth | Telephone Number |
|---|---|---|
| Patient Address | | |

**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:

1. Information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT (except psychotherapy notes which may require additional authorization), GENETIC TESTING, and/or CONFIDENTIAL HIV-RELATED INFORMATION will not be shared unless I give specific permission. By placing my initials below in **Item (#8)**, I specifically authorize the release of such information to the person(s) indicated on this form.
2. Except for the special types of information listed above, information that is shared because of this authorization may be shared again by the recipient and no longer protected by federal or state law. Unless permitted by federal or state law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (1-888-392-3644) or the New York City Commission of Human Rights at (718-722-3131). These agencies are responsible for protecting my rights.
3. I can revoke this authorization by writing to the provider/entity to whom I submitted the form. This request to revoke my authorization will be effective except to the extent Mount Vernon Neighborhood Health Center Inc. has already taken action upon this authorization.
4. Signing this authorization is voluntary. Mount Vernon Neighborhood Health Center Inc. may not place a condition on treatment, payment, enrollment in health plans, or eligibility for benefits on my signing this authorization. I understand that I may be denied treatment in some circumstances, if I do not sign this consent.

**5. Name and Address of Provider or Entity to Release this Information**:

**6. Name and Address of Person(s) to Receive this Information**:

| 7. **Description of information to be released**: | 8. **Also include**: (By initialing below) |
|---|---|
| ☐ Entire Medical Record, including patient histories, office notes, test results, radiology/films, consults, billing, referrals, transferred records etc.<br>☐ Medical record from: __________________ to __________________<br>☐ Other: ______________________________________________<br>☐ Format/CD | _________: Mental Health Information<br>_________: Alcohol/Drug Treatment<br>_________: HIV-Related Information<br>_________: Genetic Information<br>_________: Sexually Transmitted Disease |
| **9**. Purpose for Release of Information:<br>☐ At my request<br>☐ Continuity of patient care ☐ Other: | **10**. Date Authorization Expires: |

I have completed all items on this form and my questions have been answered. In addition, I have been provided a copy of the form.

Signature: ___________________________________________ Date: _________________________

Patient or Patient Authorized Representative

**For Office Use Only:** MRN#: __________________ Received: ____/____/____ Initials: _____

AA/Revised – Authorization Form/01-15-20