BRIDGES TO BRIGHT FUTURES

Authorization for Release of Confidential HIV*-related and/or other sensitive Information

CHILD'S NAME (LAST, FIRST, M.I.)			
DATE OF BIRTH:	SEX: Male ❑ Female	MEDICAID CIN #:	DATE:

This authorization must be completed by the child's medical consenter (parent or legal guardian) to use/disclose protected health information in relation to the Suffolk County Early Intervention Program, in accordance with applicable State and Federal Laws and Regulations. This authorization permits the use or disclosure of confidential human immune deficiency virus (HIV)-related information, illness or AIDS or any information which identifies or reasonable could identify a person as having one or more of such conditions, including information pertaining to such person's contacts.
➔ Under New York State law, confidential HIV-related information can only be given to persons you allow to have it by signing a release.

PART 1: AUTHORIZATION TO RELEASE INFORMATION: INCLUDING CONFIDENTIAL HIV-RELATED AND OTHER SENSITIVE INFORMATION

Description of information to be used/disclosed:
❑ Information pertinent to the child's health and medical condition, including confidential HIV-related information
❑ Other (please describe)

PURPOSE OR NEED FOR INFORMATION:

Disclosure of this information is authorized by the parent or legal guardian. The purpose of this disclosure is:
❑ Ongoing service delivery and planning.
❑ Other (please describe):

From: Name, address and title of person/organization/ facility/program(s) disclosing information.	**To:** Name, address and title of person/organization/ facility/program(s) to which this disclosure is made.
Bridges to Bright Futures	**NOTE:** If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.
PO Box 6	
Bellport, NY 11713	

A. I hereby permit the use or disclosure of the above information including confidential HIV-related information, to the person/organization/facility/program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.

2. This information is confidential and cannot legally be disclosed without my permission.

3. A recipient of confidential HIV-related information is NOT permitted to re-disclose confidential HIV-related information to anyone else without my specific written consent or as otherwise permitted by law.

4. If information that is NOT confidential HIV-related information or otherwise confidential under law is disclosed to someone who is not required to comply with Federal privacy protection regulations, then the information may be disclosed and would no longer be protected.

5. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program(s)) or an equivalent form, if that form is not available.
I am aware that my revocation will not be effective in regard to actions taken prior to the revocation if the persons I have authorized to use and/or disclose the protected health information have already taken action because of my earlier authorization.

6. I do not have to sign this authorization. My refusal to sign will not affect the ability to obtain services through the early intervention program.

7. I have a right to inspect and copy the protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524).

FACILITY / AGENCY NAME	CHILD'S NAME (LAST, FIRST, M.I.)
B. Periodic use/disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above. My authorization will expire: ❑ When I am no longer receiving services from (insert name of facility/program); ❑ One year from this date; ❑ Other:	
C. Medical Consenter Signature: I certify that I authorize the use of health information including confidential HIV-related information as set forth in this document.	
MEDICAL CONSENTER'S SIGNATURE: X	DATE:
MEDICAL CONSENTER'S NAME PRINTED:	
WITNESS SIGNATURE: X	
WITNESS NAME PRINTED:	WITNESS TITLE:
WITNESS AGENCY:	DATE:

HIV/AIDS specific information: for questions/complaints regarding HIV/AIDS discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

This information has been disclosed from confidential records protected by state law. State law prohibits the recipient of these confidential records from making any further disclosures of this information without specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure of confidential HIV information is in violation of state law and may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

** Human Immune Deficiency Virus that causes AIDS*

PART 2: REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION	
I hereby revoke my authorization to use/disclose information indicated in Part 1, to the person/organization/facility/program(s) whose name and address is:	
I hereby refuse to authorize to use/disclose indicated in Part 1, to the person/organization/facility/program(s) whose name and address is:	
MEDICAL CONSENTER'S SIGNATURE: X	DATE:
MEDICAL CONSENTER'S NAME PRINTED:	