The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services (ACCES-VR)

Authorization to Obtain or Release Confidential HIV/AIDS Related Information

Consumer Name (First, Middle, Last)	Date of Birth
Address	City/State/Zip Code

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

1. **I understand that: This authorization permits the obtaining or disclosing of information relating to CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**
2. **With some exceptions, health information once disclosed cannot be re-disclosed by the recipient for any other purpose without my authorization, unless permitted to do so under federal or state law.**
3. **Signing this authorization is voluntary. I understand that application or eligibility for services will not be conditional upon my authorization of this form.**
4. **If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.**

Name and address of person and/or facility releasing HIV/Aids Information:
Name and address of person and/or facility to whom HIV/Aids information will be disclosed:
Purpose for Release of HIV/Aids Information
Time period release is authorized: From:_____ ____ _____ (Month Day Year) To: _____ ____ ______ (Month Day Year)

Under the New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release form. If you sign this form, HIV related information can be given to people listed on the form, and for the reason(s) listed on the form. You do not have to sign this form, and you can change your mind at any time.

____ ______________

Signature of Consumer or Representative Authorized by Law Date

Witness Statement: I have witnessed the execution of this authorization by the consumer or their authorized representative

_______________________ ______________

Staff Person's Name Date

Instruction for Completing HIV/AIDS Release Form

This form is to be used for Obtaining or Releasing Consumer information on HIV/AIDS.
Under New York State Law HIV related information can only be Obtained or Released with a signed written release.

Please complete all sections of the Authorization to Obtain or Release Health Information related to HIV/AIDS.

To obtain information:

- Enter the name of the person and/or facility who will send the records in the box, Name and address of person releasing HIV/Aids Information.
- Enter the name of the ACCES staff person to who will receive the information in the box, Name and address of person to whom HIV/Aids information will be disclosed:

To release information:

- Enter the name of the ACCES Staff person who will send the records in the box, Name and address of person releasing HIV/Aids Information.
- Enter the name of the person and/or facility to whom the information will be sent to in the box, Name and address of person to whom HIV/Aids information will be disclosed.
- Enter a brief description of the reason for the release of information.
- Enter the dates for the time period being covered under this form.

The consumer or their legally authorized representative must sign and date the form.

ACCES-VR Staff are to witness all signed forms by the consumer or their legally authorized representative.