PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the Queens World Trade Center Health Program at North Shore LIJ to provide my medical records to:

NAME:	
ADDRESS:	
PHONE:	**FAX:**

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records. I also understand that this authorization may be revoked by me at any time.

PATIENT NAME:	**DOB:**	**WTCHP ID:**

Patient Signature:_____Date:_____

Patient's Personal Representative:

Signature: _____Print Name:_____

Authority:_____Date:_____

Address:_____Phone:_____

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from disclosing any HIV-related information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be disclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature:_____Date:_____

Patient's Personal Representative:

Queens WTC Clinical Center of Excellence at North Shore-LIJ
97-77 Queens Boulevard, 9th Floor
Tel. 718-267-2420/ Fax. 718-267-2445

Signature: _____Print Name:_____

Authority:_____Date:_____

Address:_____Phone:_____