Department of Education

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA FOR PURPOSE OF BLOOD-BORNE PATHOGEN POST-EXPOSURE TREATMENT AND FOLLOW-UP

Employee Name	Date of Birth	Social Security Number
Employee's School or Work Location, Address (including Room №), City/State/Zip, Telephone and Email		
Employee's Home Address, City/State/Zip, Telephone and Email		

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

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I understand that:

1. This authorization includes disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV[i] RELATED INFORMATION**. I understand that, due to the special nature of this authorization in relation to incidents of blood-borne pathogen exposure, the usual separate authorizations for HIV-related, alcohol or drug treatment, or mental health treatment information do not apply, and I make all such authorizations by my signature below. In the event the health information described below includes any of these types of information, I specifically authorize release of such information to the person(s) indicated in Item 8.

2. The recipient of HIV-related, alcohol or drug treatment, or mental health treatment information is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information. I may contact the N.Y.S. Division of Human Rights at (212) 480-2943 or the N.Y.C. Commission of Human Rights at (212) 306-7450. These agencies are responsible to protect my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (B).**

7. Name and address of health provider to release this information: **New York City Health and Hospitals Corporation** ("HHC"), 125 Worth Street, New York NY 10013, on behalf of one of its hospital units providing medical service to the undersigned.

8. Name and address of person(s) to whom this information will be sent: **Board of Education of the City School District of the City of New York (d/b/a New York City Department of Education)**, 65 Court Street, Room 706, Brooklyn, NY 11201-4954 (includes Office of the Chancellor, Division of Human Resources, Office of Occupational Safety & Health, Office of Legal Services, Office of Labor Relations, Division of School Facilities (for custodial staff only), and employee's immediate supervisors).

9.1. Specific information to be released: Entire Medical Record maintained by HHC pertaining to my treatment, counseling, etc., for exposure to blood-borne pathogens including, but not limited to, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to HHC by other health care providers. This includes: **Alcohol/Drug Treatment**, **Mental Health Information** and **HIV-Related Information**.

9.2. By initialing here _____, I authorize the **New York City Health and Hospitals Corporation** to discuss my health information with my attorney and/or a governmental agency listed here:

_____
(Attorney/Firm Name and/or Governmental Agency Name)

10. Reason for information release: My request to enable my employer to administer my treatment benefits.	11. Date or event on which this authorization will expire: My separation from employment or my written revocation.
12. If not the patient, name of person signing this form:	13. Authority to sign on patient's behalf:

All items on this form are completed and my questions about this form have been answered. I have been provided a copy of this form.

_____ Date: _____

Signature of patient or representative authorized by law.

[i] **Human Immunodeficiency Virus causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**