AHRC New York City
(NYSARC, Inc., New York City Chapter)
AHRC Homecare Services, Inc.

INDIVIDUAL AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Individual Name: _____ **Date of Birth:** _____
ID Number: _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A representative of AHRC must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? Name and address of the person(s) or class of persons authorized to disclose the information are described below.

AHRC New York City | 83 Maiden Lane | New York, NY 10038

Who will use and/or receive the information? The name and address of the person(s) or class of persons authorized to use and/or receive the information are described below.

The City University of New York | 555 West 57th Street | New York, NY 10019

What information will be used or disclosed? *The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.*
The following information may be used or disclosed:

- ☐ **Service Record from (insert date) _____ to (insert Date) _____**
- ☐ **Entire Service Record including office notes, mental health information, (except psychotherapy notes), consults, billing records, insurance records, and records sent to you by other providers**
- ☑ **Other:** Student Application and Supplemental Application Materials for admissions to AHRC New York City's Melissa Riggio Higher Education Program at the City University of New York

The following information in your chart will only be released if you indicate by initialing below:
_____ Alcohol/Drug Treatment
_____ HIV-related Information (Human Immunodeficiency Virus that 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)

Authorization to Discuss Health Information:

By initialing here _____ I authorize AHRC New York City **to discuss my health**
(Initials) **(Name of Service Provider)**
information with my attorney, or a governmental agency, listed here:

The City University of New York
(Attorney/Firm Name or Governmental Agency Name)

What is the purpose of the use or disclosure?

The purposes for which the information will be used or disclosed are described below.

The HIPPA-2 authorizes AHRC New York City to disclose information included on the student application and supplemental application materials to the City University of New York for admissions, eligibility, and student verification purposes.

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below. *In any event, this authorization will expire no later than one year from the signature date.*

This authorization will expire upon completion or termination from program services should the applicant be accepted for admissions into AHRC New York City's Melissa Riggio Higher Education Program at the City University of New York.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, except as described below, and in that event such information may no longer be protected by the federal HIPAA privacy regulations.

If you are specifically authorizing the release of HIV-related, mental health or alcohol and drug abuse treatment information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your 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 **(888) 392-3644** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting your rights. You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You have a right to see and copy the information described on this authorization form in accordance with agency policies. You also have a right to receive a copy of this form after you have signed it. If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the agency has already taken action based upon your authorization. To revoke this authorization, please write to the Privacy Officer at the agency.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Individual or Personal Representative _____ Date _____

Print Name of Individual or Personal Representative _____ Date _____

Description of Personal Representatives Authority _____ Date _____

CONTACT INFORMATION

The contact information of the individual or personal representative who signed this form should be filled in below.

Address: _____

Telephone Day: **( )** _____ Telephone Evening: **( )** _____

THE INDIVIDUAL OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

FOR AGENCY USE ONLY: Signature and Date of Privacy Officer's approval to release

Agency Privacy Officer _____ Date _____