



WESTCHESTER COMMUNITY HEALTH CENTER
(formerly known as Mount Vernon Neighborhood Health Center)
**AUTHORIZATION FOR RELEASE OF HEALTH AND
 CONFIDENTIAL HIV-RELATED INFORMATION**

- WCHC Mount Vernon WCHC Yonkers WCHC Greenburgh WCHC Lake Street WCHC at Grasslands Homeless Shelter
 WCHC at The Coachman Family Center WCHC at Edward Williams Elementary School WCHC at Mount Vernon High School

Patient Name	Patient Date of Birth	Telephone Number
Patient Address		

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

I understand that:

- Information relating to **Alcohol/Drug Treatment, Mental Health Treatment** (except psychotherapy notes which may require additional authorization), **Genetic Testing**, and/or **Confidential HIV-Related Information** will not be shared unless I give specific permission. By placing my initials below in **Item (#8)**, I specifically authorize the release of such information to the person(s) indicated on this form.
- Except for the special types of information listed above, information that is shared because of this authorization may be shared again by the recipient and no longer protected by federal or state law. Unless permitted by federal or state law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (1-888-392-3644) or the New York City Commission of Human Rights at (718-722-3131). These agencies are responsible for protecting my rights.
- I can revoke this authorization by writing to the provider/entity to whom I submitted the form. This request to revoke my authorization will be effective except to the extent Westchester Community Health Center has already taken action upon this authorization.
- Signing this authorization is voluntary. Westchester Community Health Center may not place a condition on treatment, payment, enrollment in health plans, or eligibility for benefits on my signing this authorization. I understand that I may be denied treatment in some circumstances, if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Receive this Information:

<p>7. Description of information to be released:</p> <input type="checkbox"/> Entire Medical Record, including patient histories, office notes, test results, radiology/films, consults, billing, referrals, transferred records etc. <input type="checkbox"/> Medical record from: _____ to _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Format/CD	<p>8. Also include: (By initialing below)</p> _____: Mental Health Information _____: Alcohol/Drug Treatment _____: HIV-Related Information _____: Genetic Information _____: Sexually Transmitted Disease
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<p>9. Purpose for Release of Information:</p> <input type="checkbox"/> At my request <input type="checkbox"/> Continuity of patient care <input type="checkbox"/> Other:	<p>10. Date Authorization Expires:</p>
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I have completed all items on this form and my questions have been answered. In addition, I have been provided a copy of the form.

Signature: _____ Date: _____
 Patient or Patient Authorized Representative

For Office Use Only: MRN#: _____ Received: ____/____/____ Initials: _____