ST. JOHN'S UNIVERSITY

Center for Counseling & Consultation (CCC)

Authorization for Release of Treatment Records

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE TREATMENT RECORD OF:

Last Name_____ First Name_____ Date of Birth___/_____/_____

Email Address_____ X#_____ Phone #_____

Address_____ City_____ State_____ Zip Code_____

2. RELEASE RECORDS □ FROM or □ TO ↔ RELEASE RECORDS □ FROM or □ TO

St. John's University Center for Counseling & Consultation Name/Organization_____

8000 Utopia Parkway Street Address_____

Queens, New York 11439 City / State / Zip Code_____

Phone: 718-990-6384 Fax: 718-990-2609 Phone___/_____/_____ Fax___/_____/_____

□ Mail records □ Fax records □ Discuss verbally (no copying of records necessary) □ Pick up

3. INFORMATION TO BE RELEASED FROM YOUR TREATMENT RECORD

	YOUR INITIALS ARE REQUIRED		YOUR INITIALS ARE REQUIRED
□ Intake report	•_____	□ Summary of evaluation and treatment	•_____
□ Termination summary	•_____	□ Entire record	•_____

4. SPECIAL INSTRUCTIONS_____

5. REASON FOR RELEASE OF INFORMATION_____

6. SIGNATURE OF PATIENT/CLIENT (or representative authorized by law)

- I understand that signing this form is voluntary. My treatment or eligibility for services will not be conditioned upon my authorization of this disclosure.
- Unless otherwise revoked, this authorization will expire on (date or event)_____.
- I may revoke this authorization in writing at any time, except to the extent that CCC has already relied on this authorization.
- I may revoke it by sending a written notice to the CCC stating my intent to revoke this authorization.
- I understand that the records related may include information relating to HIV or AIDS, and I have read the reverse side of this form.

• I understand that the records released may include information relating to treatment for or history of drug or alcohol abuse.

• I understand that information disclosed under this authorization might be redisclosed by the recipient and may no longer be protected by privacy laws.

• I understand that a photocopy of facsimile copy of this authorization shall be considered as effective and valid as the original.

I have read and fully understand the above statements and consent to the disclosure of my treatment record for the purpose and to the extent stated above.

• Signature_____ • Date_____

• I am under 18 years of age; therefore, I understand that my parent/guardian must also sign this document.

• _____/_____ • Date_____
Parent/Guardian Signature Printed Name

CCC USE ONLY Date released:_____Released by:_____

Notes:_____

Release of HIV-Related Information

□ Please be aware that the records you have authorized for release may include information relating to discussion, testing, or treatment of HIV or AIDS. •_____ (Initials are required)

□ If you do not want such information to be included in this release, please write "exclude HIV-related information" in the "Special Instructions" area of this form. •_____ (Initials are required)

Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV infection, HIV related illness, or AIDS, or any information that could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV-related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide special care and services, including: medical care providers; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals or other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care of treatment. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law.

For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 800-962-5065.

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 800-523-2437 or 212-480-2493, or the New York City Commission of Human Rights at 212-306-5070. These agencies are responsible for protecting your rights.