The Arc
Allegany-Steuben
New York

Authorization to Release PHI

Name: _____ **Date**: _____

SPECIFIC UNDERSTANDINGS

The Arc Allegany-Steuben understands 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 you are properly informed of how information will be used or disclosed. Please read the information below carefully before signing this form. If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from disclosing 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/Commission of Human Rights toll free at 1-888-392-3644. General inquiries may also be directed to **info@dhr.ny.gov**. Contact the Division via TDD/TTY at 718-741-8300. This agency is responsible for protecting your rights.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described below. This information may be disclosed by the recipient(s) described on this form if they are not required by law to protect the privacy of the information, and in that event, such information may no longer be protected by the federal HIPAA privacy regulations. 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 Arc Allegany-Steuben at: One Arc Way, Bath NY 14810 attn. Privacy Officer.

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

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

The Arc Allegany-Steuben Internal Check List:
If the person has a Legal Guardian, did you get his/her permission and send for signature?_____
Department Sent By:_____
Name of Person Sent By:_____
Date Recorded on Accounting of Disclosures_____

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USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

Who will disclose the information? The person(s) or class of persons authorized to disclose the information is described below.

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information is described below.
Allegany-Steuben Counties Chapter NYSARC, Inc.

What specific information will be used or disclosed?
School records; IEP, Psychological, work history, and any other records pertinent to obtaining a community based internship. This consent will also allow for on-going communication between the school district and the Arc Allegany-Steuben.

- ❑ The following HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV):

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below.
Determine eligibility for services, assist with service planning and internship development. Continuity of services.

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below. No more than 6 months from date of signature.

SIGNATURE

All information below must be completed.
If you have a Legal Guardian, his/her signature is required.

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 Person or Personal Representative Date

Print Name of Person or Personal Representative

Description of Personal Representative's Authority

CONTACT INFORMATION

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

The Arc
Allegany-Steuben
New York

Phone (day): _____ (eve): _____