HELEN HAYES
HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Authorization to Release Personal Health Information

I hereby authorize Helen Hayes Hospital to disclose and release all of the health information possessed or maintained by the Hospital, including any psychiatric or drug/alcohol history, of:

Patient's full name _____ Date of birth _____

Information to be released: _____

Name of recipient	Address	City, State	Zip

I specifically authorize the disclosure of HIV/AIDS information (if applicable) unless the box below is initialed:

☐ DO NOT disclose HIV/AIDS information (if applicable).

I also understand that the recipient of my health information may not be required to comply with laws that protect the confidentiality of my health information and may re-disclose it to others. State law governs the release of HIV/AIDS-related information. Federal law governs release of substance abuse records and requires consent for their release unless otherwise provided for in 43 CFR Part 2.

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Signature of patient, or if patient cannot consent, signature of person legally authorized to consent on behalf of patient _____ Date _____

If the signature is of a person other than the patient, describe the person's authority to act on behalf of the patient (examples: parent or legal guardian of a minor, health care proxy):

Print Name _____ Authority to Act _____

This authorization is subject to revocation at any time except to the extent that the Helen Hayes Hospital has already taken action in reliance on it. My revocation must be made in writing to the Medical Records Department of the Hospital. If not previously revoked, this authorization will expire ninety days after the date of signature.