

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

31 Woodlawn Avenue, Saratoga Springs, NY 12866-2198

Telephone: (518) 584-7460

FAX: (518) 583-1202 OR (518) 583-2498

www.co.saratoga.ny.us/phindex.html



POLICY/PROCEDURE FOR RELEASE OF CONFIDENTIAL HIV RELATED PATIENT INFORMATION

DEFINITION

New York State Department of Health defines "confidential HIV related information" as any information in the possession of a person who provides health or social services or who obtains the information pursuant to a release of confidential HIV related information concerning whether an individual has been the subject of an HIV related illness or AIDS, or information which identifies or could reasonably identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

The agency recognizes and respects the importance of ensuring the confidentiality of HIV related information.

Confidential HIV related information will only be released following the specific procedures defined below. All Saratoga County Public Health employees will receive initial and annual education regarding the handling of confidential HIV information before access to such information is permitted.

PROCEDURE

1. All personnel included in the Job Titles list with access to confidential HIV information will be oriented to the HIV Confidentiality Regulations (Public Health Law – Article 27-F) at the start of employment. Annual inservice regarding the legal prohibition against unauthorized disclosure will be provided. Documentation of attendance at these education programs will be made in each employee and contract staff's personnel file. See Attachment B.
2. A list of job titles and the specific employee functions within those titles for which employees are authorized to access such information will be maintained by the agency. See Attachment A. A copy of this list will be given to all new employees during employee education sessions.
3. All active patient records are stored in file cabinets with locks. At the end of each workday, the room where the records are located will be secured and locked.
4. The agency will release such information only with the specific Release Form (DOH-2557), which has been approved by the New York State Department of Health and signed by the protected individual. See Attachment C. If the protected individual lacks the capacity to consent, this form must be signed by a person authorized pursuant to law to consent to healthcare for the individual. Exceptions to this requirement are limited to (a) insurance companies for reimbursement purposes, (b) other exceptions as noted in Public Health Law Section 2786, Part 63.5 – Confidentiality and Disclosure.
5. All written disclosures will be accompanied by the following statement, which prohibits redisclosure. Verbal disclosures will be documented in the patient record and will be followed (no later than ten days) by a written copy of the statement.

NEW YORK CONFIDENTIALITY STATEMENT

“This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized, further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both.” See Attachment D.



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JOB TITLES

Director of Public Health
Director of Patient Services
Director of Preventive Health Services
Supervising Public Health Nurses
Public Health/Registered Nurses
Supervising Physical Therapist
Physical Therapists
Occupational Therapists
Speech/Language Pathologists
Medical Social Worker
Nutritionist
Early Intervention Care Coordinators
Home Health Aide/Personal Care Aide/Homemaker
Financial/Fiscal Manager
Medical Secretary
Information Processing Specialist
Senior Account Clerk
Account Clerk Typists
Senior Typist
Typists

NOTE: Job Descriptions/Functions are available in the Policy Book Appendix.

Our mission: To assess, improve and monitor the health status of our community.

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. 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 medical and/or HIV-related 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 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- My HIV-related information
- Both (non-HIV medical and HIV-related information)
- My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information: _____ _____
Name of person whose information will be released: _____
Name and address of person signing this form (if other than above): _____ _____
Relationship to person whose information will be released: _____ _____
Describe information to be released: _____
Reason for release of information: _____
Time Period During Which Release of Information is Authorized From: _____ To: _____
Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any: _____ _____
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____ _____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____ Date _____

*Human Immunodeficiency Virus that causes AIDS
** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

**HIPAA Compliant Authorization for Release of Medical Information
and Confidential HIV* Related Information**

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

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 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

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If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____

Date _____

Client/Patient Number _____



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HIV POSITIVE CONFIDENTIALITY STATEMENT

Date _____

Patient Name _____ Date of Birth _____

ALL WRITTEN AND VERBAL DISCLOSURES OF CONFIDENTIAL HIV INFORMATION MUST BE ACCOMPANIED BY THE STATEMENT PROHIBITING REDISCLOSURES.

“This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized, further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both.”

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