

**Attachment 16**  
**Ending Epidemics Education, Training and Technical Assistance Services**  
**RFA #20760/Internal Program #25-0003**

ATTACHMENT E-1, AIDS Institute Policy on Personal Health Related Information

**Access to and Disclosure of Personal Health Related Information**

**1. Statement of Purpose**

The purpose of this policy is to set forth methods and controls to restrict dissemination and maintain control of confidential personal health related information by contractors, subcontractors and other agents of the Department of Health AIDS Institute.

**2. Definition**

For the purpose of this policy, personal health related information means any information concerning the health of a person which identifies or could reasonably be used to identify a person.

**3. Access**

(a) Contractors, subcontractors or other agents of the Department of Health AIDS Institute are not to have access to personal health related information except as part of their official duties;

(b) Access to personal health related information by contractors, subcontracts or other agents of the Department of Health AIDS Institute is to be authorized only after employees have been trained in the responsibilities associated with access to the information;

(c) Contractors, subcontractors, or other agents of the Department of Health AIDS Institute may be authorized to have access to specific personal health related information only when reasonably necessary to perform the specific activities for which they have been designated.

**4. Disclosure**

All entities, organizations and community agencies who contract with the AIDS Institute shall utilize a Department of Health-approved "Authorization For Release of Confidential HIV Related Information" form (Form DOH-2557 or DOH-2557es), copies of which are included in this Attachment E, when receiving or requesting HIV-related information. No contractor, subcontractor or other agent of the Department of Health AIDS Institute who has knowledge of personal health related information in the course of employment, shall disclose such information to any other person unless such disclosure is in accordance with law, DOH regulations and policy, and the information is required to perform an officially designated function.

**5. Disposition**

Documents containing personal health related information shall be disposed of in a manner in which the confidentiality will not be compromised.

**6. Confidentiality Protocols**

(a) Each contractor, subcontractor or other agent of the Department of Health AIDS Institute will develop confidentiality protocols which meet the requirements of this section. The protocols shall include as necessary:

(1) measures to ensure that letters, memoranda and other documents containing personal health related information are accessible only by authorized personnel;

(2) measures to ensure that personal health related information stored electronically is protected from access by unauthorized persons;

(3) measures to ensure that only personal health related information necessary to fulfill authorized functions is maintained;

- (4) measures to ensure that staff working with personal health related information secure such information from casual observance or loss and that such documents or files are returned to confidential storage on termination of use;
- (5) measures to ensure that personal health related information is not inappropriately copied or removed from control;
- (6) measures to provide safeguards to prevent discrimination, abuse or other adverse actions directed toward persons to whom personal health related information applies;
- (7) measures to ensure that personal health related information is adequately secured after working hours;
- (8) measures to ensure that transmittal of personal health related information outside of the contractor, subcontractor or other agent of the Department of Health AIDS Institute is in accordance with law, Department of Health regulation and policy;
- (9) measures to protect the confidentiality of personal health related information being transferred to other units within the contractor, subcontractor or other agent's operation; and
- (10) measures to ensure that documents or files that contain personal health related information that are obsolete or no longer needed are promptly disposed of in such a manner so as to not compromise the confidentiality of the documents.

(b) Protocols for ensuring confidentiality of personal health related information are to be updated whenever a program activity change renders the established protocol obsolete or inadequate.

## **7. Employee Training**

(a) Employees of contractors, subcontractors of other agents of the Department of Health AIDS Institute are to be trained with respect to responsibilities and authorization to access personal health related information.

(b) Employees authorized to access personal health related information are to be advised in writing that they shall not:

- (1) examine documents or computer data containing personal health related information unless required in the course of official duties and responsibilities;
- (2) remove from the unit or copy such documents or computer data unless acting within the scope of assigned duties;
- (3) discuss the content of such documents or computer data with any person unless that person had authorized access and the need to know the information discussed; and,
- (4) illegally discriminate, abuse or harass a person to whom personal health related information applies.

## **8. Employee Attestation.**

Each employee, upon receiving training, shall sign a statement acknowledging that violation of confidentiality statutes and rules may lead to disciplinary action, including suspension or dismissal from employment and criminal prosecution. Each employee's signed attestation is to be centrally maintained in the employee's personal history file.

## Authorization for Release of Health Information and Confidential HIV-Related Information\*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only 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 New York 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 health 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 more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

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

- I consent to disclosure of (please check all that apply):
- My HIV-related information
  - My non-HIV health information
  - Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related 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: \_\_\_\_\_

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):  
\_\_\_\_\_  
\_\_\_\_\_

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information  
and Confidential HIV-Related Information\***

**Complete information for each facility/person to be given general 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 health 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 health 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 City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health 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 health 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 \_\_\_\_\_

**\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information  
and Confidential HIV-Related Information\***

**Complete information for each facility/person to be given general 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 health and/or HIV-related information:

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

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

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

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

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

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

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

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number \_\_\_\_\_

**\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

## Autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH

Este formulario autoriza la divulgación de información sobre salud incluyendo la información relacionada con el VIH. Usted puede elegir divulgar solo la información sobre su salud no relacionada con el VIH, solo la información sobre su salud relacionada con el VIH, o ambas. Su información puede estar protegida contra la divulgación por la legislación federal y estatal sobre privacidad. La información confidencial relacionada con el VIH es toda información que indica que una persona se ha realizado una prueba relacionada con el VIH, o está infectada con VIH, padece una enfermedad relacionada con el VIH o cualquier otra información que pueda indicar que una persona ha estado potencialmente expuesta al VIH.

Conforme a lo dispuesto por la legislación del estado de Nueva York, la información relacionada con el VIH solo puede entregarse a las personas que usted haya autorizado mediante un permiso escrito de divulgación. Esta información también puede ser divulgada a los siguientes prestadores de salud que le brindan cuidados a usted o a su hijo expuesto: funcionarios de salud cuando la ley así lo requiera; aseguradores, para autorizar un pago; personas involucradas en cuidados de crianza o adopción; personal oficial correccional, de libertad condicional y bajo palabra; personal de emergencia o de atención de la salud accidentalmente expuestos a su sangre, o por orden judicial especial. En virtud de la ley del estado de Nueva York, a las personas que divulguen ilegalmente información relacionada con el VIH se les puede aplicar una multa de hasta \$5000 y hasta un año de cárcel. Sin embargo, algunas divulgaciones posteriores de información relacionada con la salud o el VIH no están protegidas por la legislación federal. Para obtener más información sobre la confidencialidad del VIH, llame a la línea gratuita de confidencialidad sobre VIH del Departamento de Salud del estado de Nueva York al 1-800-962-5065; para obtener más información sobre protección federal de la privacidad, llame a la Oficina de derechos civiles al 1-800-368-1019. También puede comunicarse con la División de Derechos Humanos del estado de Nueva York al 1-888-392-3644.

Las marcas en las siguientes casillas y su firma en este formulario autorizan la entrega de información sobre salud o relacionada con el VIH a las personas que aparecen en la página dos (y en hojas adicionales en caso de ser necesario) del formulario, por el(los) motivo(s) indicado(s). Usted puede solicitar a la institución o persona que divulga la información sobre su salud que le entregue una copia de este formulario.

- Autorizo la divulgación de (marque lo que corresponda):
- Mi información relacionada con el VIH
  - Mi información de salud no relacionada con el VIH
  - Ambas (información de salud no relacionada con VIH e información relacionada con VIH)

Nombre y domicilio de la institución/persona que divulga la información relacionada con el VIH:

\_\_\_\_\_

\_\_\_\_\_

Nombre de la persona cuya información será divulgada: \_\_\_\_\_

Nombre y domicilio de la persona que firma este formulario (si difiere de las anteriores):

\_\_\_\_\_

\_\_\_\_\_

Relación con la persona cuya información será divulgada: \_\_\_\_\_

\_\_\_\_\_

Describir la información que se va a divulgar: \_\_\_\_\_

Motivo de divulgación de la información: \_\_\_\_\_

Período durante el cual se autoriza la divulgación de la información: Desde: \_\_\_\_\_ Hasta: \_\_\_\_\_

Excepciones al derecho de revocar el consentimiento, si existe alguna:

\_\_\_\_\_

\_\_\_\_\_

Descripción de las consecuencias, en caso de existir, sobre el tratamiento, pago, registro o elegibilidad para obtener beneficios, si no se autoriza la divulgación  
(Nota: los reglamentos federales de privacidad pueden restringir algunas consecuencias):

\_\_\_\_\_

\_\_\_\_\_

Firme abajo **solo** si desea autorizar a todas las instituciones/personas indicadas en las páginas 1, 2 (y 3, si se utilizó) de este formulario a compartir información entre sí con el fin de proveer atención y servicios de salud.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_

**\* Esta autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH cumple con la HIPAA. Si solo se divulga información de salud no relacionada con el VIH, puede utilizar este formulario u otro formulario de divulgación de salud general que cumpla con lo dispuesto por la HIPAA.**

**Autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH\***

**Completar la información de cada institución/persona a la que se entregará información general o información relacionada con el VIH. Agregar más hojas según sea necesario. Se recomienda tachar las líneas en blanco antes de firmar.**

Nombre y domicilio de la institución/persona a la que se dará la información general sobre salud o relacionada con el VIH:

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Motivo de la divulgación, si es distinto del motivo indicado en la página 1:

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Si la información que se va a divulgar a esta institución/persona es limitada, indíquelo:

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Nombre y domicilio de la institución/persona a la que se dará la información general sobre salud o relacionada con el VIH:

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Motivo de la divulgación, si es distinto del motivo indicado en la página 1:

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Si la información que se va a divulgar a esta institución/persona es limitada, indíquelo:

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La ley lo protege de la discriminación relacionada con el VIH con respecto a vivienda, empleo, atención de la salud y otros servicios. Para obtener más información, llame a la Comisión de Derechos Humanos de la Ciudad de Nueva York al (212) 306-7500 o a la División de Derechos Humanos del estado de Nueva York al 1-888-392-3644.

Se han respondido mis preguntas sobre este formulario. Sé que no debo permitir que se divulgue la información sobre mi salud o la información relacionada con el VIH, y que puedo cambiar de opinión en cualquier momento y revocar la autorización notificando por escrito a la institución/persona a la que se dio el permiso de divulgación. Autorizo a la institución/persona indicada en la página uno a divulgar información relacionada con la salud o el VIH de la persona nombrada en la página uno a las organizaciones/personas indicadas.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_  
(SUJETO DEL QUE SE INFORMA O REPRESENTANTE LEGALMENTE AUTORIZADO)

Si se trata del representante legal, indique relación con el sujeto:

Nombre en letra de molde \_\_\_\_\_

Número de cliente/paciente \_\_\_\_\_

\* Esta autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH cumple con la HIPAA. Si solo se divulga información de salud no relacionada con el VIH, puede utilizar este formulario u otro formulario de divulgación de salud general que cumpla con lo dispuesto por la HIPAA.

**Autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH\***

**Completar la información de cada institución/persona a la que se entregará información general o información relacionada con el VIH. Agregar más hojas según sea necesario. Se recomienda tachar las líneas en blanco antes de firmar.**

Nombre y domicilio de la institución/persona a la que se dará la información general sobre salud o relacionada con el VIH:

\_\_\_\_\_  
\_\_\_\_\_

Motivo de la divulgación, si es distinto del motivo indicado en la página 1:

\_\_\_\_\_  
\_\_\_\_\_

Si la información a divulgar a esta institución/persona es limitada, indíquelo:

\_\_\_\_\_  
\_\_\_\_\_

Nombre y domicilio de la institución/persona a la que se dará la información general sobre salud o relacionada con el VIH:

\_\_\_\_\_  
\_\_\_\_\_

Motivo de la divulgación, si es distinto del motivo indicado en la página 1:

\_\_\_\_\_  
\_\_\_\_\_

Si la información a divulgar a esta institución/persona es limitada, indíquelo:

\_\_\_\_\_  
\_\_\_\_\_

Nombre y domicilio de la institución/persona a la que se dará la información general sobre salud o relacionada con el VIH:

\_\_\_\_\_  
\_\_\_\_\_

Motivo de la divulgación, si es distinto del motivo indicado en la página 1:

\_\_\_\_\_  
\_\_\_\_\_

Si la información a divulgar a esta institución/persona es limitada, indíquelo:

\_\_\_\_\_  
\_\_\_\_\_

Si toda o parte de esta página está completa, firme abajo:

Firma \_\_\_\_\_ Fecha \_\_\_\_\_  
(SUJETO DEL QUE SE INFORMA O REPRESENTANTE LEGALMENTE AUTORIZADO)

Número de cliente/paciente \_\_\_\_\_

\* Esta autorización para divulgación de Información sobre salud e información confidencial relacionada con el VIH cumple con la HIPAA. Si solo se divulga información de salud no relacionada con el VIH, puede utilizar este formulario u otro formulario de divulgación de salud general que cumpla con lo dispuesto por la HIPAA.