Department of Homeless Services
Department of Social Services

Record Release Authorization Form

I am requesting: ☐ Shelter History Letter ☐ Copy of my Case Records

Name: _____ **Date of Birth:** _____ **SSN:**_____

CARES ID: _____

I hereby authorize the Department of Homeless Services to release my records that the Agency maintains under my name to myself or my representative from: _____

Please check all that apply:

☐ I do not consent to the release of all medical and psychiatric information.

☐ I do not consent to the release of HIV-related information.

☐ I do not consent to the release of substance abuse information.

☐ I do not consent to the release of information pertaining to my status as a victim of domestic violence.

- I understand that I have the right to all of the information contained within my records.
- I understand that I can refuse to sign this form.
- I understand that my records are protected by law.
- I understand that my records may contain medical information, including psychiatric information and/or alcohol/drug abuse information.
- I understand that my records may contain HIV-related information, including any information indicating that I had an HIV- related test, or has HIV infection, HIV-related illness or AIDS, or information that I had been potentially exposed to HIV.
- I understand that my records may contain information pertaining to my status as a victim of domestic violence.
- I am aware that unless I indicate otherwise above, any HIV-related information and domestic violence-related information contained in my records can be given to the person listed on this form.
- I know that I can change my mind regarding this authorization at any time before the information is released.
- I authorize this release for a period of 180 days.
- A photocopy of this release may be sufficient.
- My signature reflects that I have read all of the above.

(Turn page)

Record Release Authorization Form *(continued)*

Note to Recipient of Confidential Information:

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 for further disclosure. NY Public Health Law, Article 27-F-§2782(5)(a).

Client Signature: _____ **Date:** _____

You must have your signature notarized or a witness to verify your identity before records may be mailed or emailed. Email delivery subject to technical constraints and file size limitations.

☐ **Mail or** ☐ **Email my records to me at the address listed below:**

_____

_____

_____

Mail Completed form to:
DSS Office of Legal Affairs - Records Access
150 Greenwich Street (38th Fl.)
New York, NY 10007

Email: RecordsAccess@dhs.nyc.gov

Fax: 917-639-0367

Notary Information Here

DHS/Provider Witness
_____ **Print name**
_____ **Signature**
_____ **Date**