

UPDATED MATERIALS

for

HIV/AIDS TESTING, CONFIDENTIALITY AND DISCRIMINATION: WHAT YOU NEED TO KNOW ABOUT NEW YORK LAW

Please note: The sample forms in Appendix A, B and D of this book (reproduced at pp. 107 – 115) are out of date and may no longer be used after June 2005. These have been replaced with revised forms issued by the New York State Department of Health (DOH), effective June 1, 2005.

The current forms that replace the ones in this book are:

- **Informed Consent to Perform an HIV Test (DOH 2556 and 2556i (6/05))**

Replaces form printed in Appendix D of this manual (at p. 112).

- **HIPPA Compliant Authorization for Release of Medical Information and Confidential HIV*Related Information (DOH 2557 (8/05))**

Replaces forms printed in Appendix A (at p. 107) and Appendix B (at p. 109) of this manual.

- **Informed Consent to Perform HIV Testing and Authorization for Release of HIV related Information for Purposes of Providing Post-exposure Care to a Health Care Worker Exposed to a Patient's Blood or Body Fluids (DOH 4054 (Rev.8/05, compliant with 45 C.F.R. of 164.508(b)(4)(iii) [HIPPA])**

New form not previously included in this manual.

These and other DOH-approved forms are available in Spanish and other languages. You can download or order copies from the New York State Department of Health website:

<http://www.health.state.ny.us/diseases/aids/forms/>

Informed Consent to Perform HIV Testing

Important Phone Numbers

New York State HIV/AIDS Hotlines (toll-free)

Call the Hotlines for information about HIV and AIDS and to find HIV testing sites

- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

New York State TTY/TTD HIV/AIDS Information Line

- 1-212-925-9560

Voice callers use the NY relay:

- 711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

New York State HIV/AIDS Counseling Hotline

- 1-800-872-2777

NYSDOH Anonymous HIV Counseling and Testing Program

For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.

- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-6785
- New Rochelle Region 1-800-828-0064
- Queens Region 1-800-462-6785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6786
- Syracuse Region 1-800-562-9423

NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5448)

New York State PartNer Assistance Program: 1-800-541-AIDS

New York City Contact Notification Assistance Program: 1-212-693-1419

Confidentiality

- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800-223-4044

Human Rights/Discrimination

- New York State Division of Human Rights 1-800-523-2437
- New York City Commission on Human Rights 1-212-306-7500

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern.

The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Part



Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556, Part B.

HIV is the virus that causes AIDS.

- HIV is passed from one person to another during unprotected sex (vaginal, anal or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing works with a person who has HIV.

The only way to know if you have HIV is to be tested.

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

Your HIV test today includes:

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- If you are HIV positive, additional tests may include tests to:
 - help your doctor decide the best treatment for you.
 - help guide the health department with HIV prevention programs.

Several testing options are available.

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don't give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and free or anonymous testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

HIV testing is important for your health.

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
 - You can take steps to prevent passing the virus to others.
 - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

HIV testing is especially important for pregnant women.

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

If you test positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:



- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:

In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Printed Name: _____

Medical Record #: _____

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556i, Part A.

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 _____

**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. Blank lines may 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:

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:

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

Signature _____ Date _____
Client/Patient Number _____

Informed Consent to Perform HIV Testing and Authorization for Release of HIV-related Information for Purposes of Providing Post-exposure Care to a Health Care Worker Exposed to a Patient's Blood or Body Fluids

An employee has been exposed to your blood or a body fluid in a manner which may pose a risk for transmission of a blood-borne infection. Many individuals may not know whether they have a bloodborne infection because people can carry these viruses without having any symptoms. We therefore are asking for consent to test you for the presence of human immunodeficiency virus (HIV), the virus that causes AIDS. You will also be tested for hepatitis B virus (HBV) and hepatitis C virus (HCV).

Under New York State law, HIV testing is voluntary and requires consent in writing (consent can be withdrawn for testing at any time.) There are a number of tests that can be done to show if you are infected with HIV. Your provider or counselor can provide specific information on these tests. Anonymous testing is available at selected sites. These tests involve collecting and testing blood, urine or oral fluid. Additional testing also will tell whether you are carrying HBV or HCV.

HIV Testing is Important for Your Health

- If your test result is negative, you can learn how to protect yourself from being infected in the future
- If your test result is positive:
 - You can take steps to prevent passing the virus to others
 - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.
- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.

If You Test Positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

If you are positive, your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department unless it would result in harm to you.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health Department will not notify partners right away and will assist you in getting help.

You are also being asked to authorize the release of confidential HIV-related information related to this consent for testing to the health professional, named below, who is treating the health care worker that has been exposed to your blood or body fluid. This is necessary to provide appropriate care and to counsel the worker about his or her risk of becoming infected and possibly infecting others. Under New York State law HIV-related information can only be given to people you allow to have it by signing a written release, except in the instances outlined above. These individuals are prohibited by law from re-disclosing testing results in a way that could reveal your identity.

Name and address of facility/provider disclosing HIV-related information: _____

Name and address of facility/provider to be given HIV-related information: _____

Describe information to be released: **HIV Test Results**

Time period during which release of information is authorized From: _____ To: _____

You may revoke this release, but disclosures cannot be revoked, once made. Additional exceptions to the right to revoke this release, if any: _____

Describe consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits. (Note: Federal privacy regulation may restrict some consequences): _____

I understand that I am being asked to submit a specimen for HIV testing for occupational exposure. I agree to testing for the determination of HIV infection. If I am found to have HIV, I agree to additional testing that may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

I also authorize release of this information to the health care professional, named above, who is treating the health care worker that has been exposed to my blood or body fluid.

Signature: _____
(Test subject or legally authorized representative)

Printed Name: _____

Date: _____

Patient ID#: _____

DOB: _____

Address: _____

If legal representative, indicate relationship to subject:
