Location: 60 Haven Avenue, New York, NY 10032
Phone (212) 305-3400 Fax (212) 342-3955
Mailing Address: Student Health Service, 630 W. 168th St., Mailbox 77, New York, NY 10032

Authorization for Release of Medical Information

Patient Name: _____ DOB: _____ MRN: _____
Phone:
Patient Address: _____ Email: _____
_____

Please check one of the boxes below.

_ I authorize Student Health Service to **release information to**:	_ I authorize Student Health Service to **obtain information from**:
_____ Name of Provider/Facility	_____ Name of Provider/Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone # / Fax # (include area code)	_____ Phone # / Fax # (include area code)

TYPE OF RECORDS REQUESTED: (Check all that apply)

_ Immunization record _ Laboratory reports _ Other studies (please specify):
_ Pap smear results _ X-ray reports _____
_ Mental Health Records ___ (Initial) _ Substance Use treatment ___ (Initial)
_ All medical records relating to a specific illness or injury. (Specify illness and dates)
_____
_ Other (please specify) _____
_____

PURPOSE FOR THIS REQUEST: _____

AUTHORIZATION VALID FOR: (Check one)

_ This request only.
_ This request and medical records of any future treatment of the type(s) described above will expire one year after date of request.

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released.
- I also understand that this authorization expires in one year from the date of request if not otherwise specified.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure
- All Information released will be reviewed prior to release.
- The above information will not be given, sold, transferred, or in any way related to any other person not specified in the consent form without first obtaining my additional written consent.
- Release of HIV-related information also requires a NYSDOH Release of information authorization.
- A copy of this signed form will be provided to me.

_____
Signature of Patient Date

For SHS use only

Chart Reviewed: _ OK to copy requested records _ Further review required **Init** _____ **Date** _____
Requested Records Copied: Init _____ **Date** _____ **Invoice sent:** _ N/A **Init** _____ **Date** _____
Requested Records: _ Mailed _ Faxed _ Left for pick up(patient notified records available) **Init** _____ **Date** _____