BARNARD
THE LIBERAL ARTS COLLEGE
FOR WOMEN
IN NEW YORK CITY

For office use only
[ ] Mailed (date) __/___/___ (initial) _____
[ ] Faxed (date) __/___/___ (initial) _____
[ ] Left at Front Desk for Pick-up (date) __/___/___ (initial) _____

Primary Care Health Service
Lower Level Brooks Hall
3009 Broadway
New York, NY 10027-6598
Phone: 212-854-2091
Fax: 212-854-2702

Authorization to Release Medical Records

This form provides the authorization necessary for the release of your protected health information. Please print legibly in black ink. Fax or mail this form, or bring it to our office. We cannot accept it via email for privacy and security reasons. Processing times vary depending on the materials you request.

Full Name: _____ Last four digits of SS #: _____ DOB: ___/____/_____

Cell phone: _____ **Email** _____ **Graduation year** _____

Authorizes Release of Protected Health Information

From:
☐ Barnard College Primary Care Health Service

To: (Name & Fax # **OR** Name & Address)
_____
_____
_____

☐ From (another provider)
_____
_____

To: Barnard College Primary Care Health Service
OR
☐ Check here if you will return to pick-up records

Specific Description of Information (choose one):

☐ **Check here for immunization records only** ☐ **Records from ___/___/___ to ___/___/___ (dates)**

☐ **Records that contain the following specified information:**
_____

☐ **I hereby give consent for the release of any HIV-related information that may be in my medical record only to the designated person(s)/clinic(s) listed above**

Charges for medical records: Current students no charge; Alumnae/previous students: $0.75/per page
Each additional U.S. fax # or address, add $1.00; International fax # or international address add $2.00

_____ ___/____ _____ _____
Visa or MasterCard (circle one) **Exp. Date** **CID (3 digits on back of card)** **billing zip code**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Director of the Barnard College Primary Care Health Service, except to the extent that Barnard College has already taken action based upon my authorizations. Unless otherwise revoked, this authorization will expire 6 months from date of signature. A copy of this form is available to me upon my request. *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

_____ Date: ___/___/____
Signature of Individual

_____
Printed Name