NYU SCHOOL OF MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Health Information Management (HIM), NYU Langone Medical Center, 560 First Avenue, New York, NY 10016

In accordance with federal and state law, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. Please read the information below carefully before signing this form. ***All fields must be completed.***

Patient Name:	**Sex:**	**Birth Date:**	☐ **Paper** ☐ **Password-Protected CD** **(fees may apply)**
Patient Address:	**Phone Number:**		

I, or my personal representative, hereby authorize NYU School of Medicine to use or disclose protected health information regarding my care and treatment. I understand that:

1. Information relating to **ALCOHOL/DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING**, and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will not be disclosed unless I specifically authorize such disclosure by placing my initials in the appropriate space(s) in Item 8(b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV-related information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the use or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent NYU School of Medicine has already relied upon this authorization.

4. Signing this authorization is voluntary. NYU School of Medicine may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. **Provider releasing this information** (one provider per form)**:**
   Name: _____
   Address: _____
   _____

6. **Purpose for release of information:**
   ☐ At my request ☐ Continuity of Care ☐ Other: _____

PLEASE COMPLETE REVERSE SIDE OF FORM

7. **Person(s) receiving this information:**

☐ Send to Name: _____

Address: _____

_____

☐ I will pick it up

☐ My personal representative _____ will pick it up.

(identification required for pick-up)

8. **Description of information being released:**

a) Specific date(s) of service (required; list all dates): _____

_____

I would like (choose one)**:**

☐ An abstract (pertinent information related to the above listed date(s))

☐ My entire Medical Record

☐ Other: _____

(b) Include information relating to (initial beside each applicable category):

Alcohol/Drug Treatment _____ **Mental Health Treatment** _____

Genetic Testing Information _____

Psychotherapy Notes _____ (If yes, complete a separate authorization form for this purpose)

HIV-related Information _____ (If yes, complete an official NYSDOH HIV release form)

9. **Date or event on which this authorization will end:**

☐ One-Time Request ☐ Specific Event or Date : _____

10. **Signature: By signing below I acknowledge that I have read and agree with all of the above.**

Signature: _____ Date: _____/_____/_____

Print name of patient or personal representative: _____

Personal representative's authority (supporting documentation required):

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor

☐ Other: _____

THE PATIENT OR PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM UPON SIGNING

Office Use Only:

MRN: _____

Date Received: _____/_____/_____

Date Completed: _____/_____/_____