

# Instructions for Requesting a Copy of your Health Record

## CLINICAL RECORDS:

Please be advised that in order to obtain a copy of your clinical health record, you must complete the form **Authorization for Release of Health Information**. The form is available as a PDF file at [www.nyu.edu/shc/medicalrecords](http://www.nyu.edu/shc/medicalrecords).

## HIV/AIDS:

If your health records contain information relating to HIV or AIDS, the New York State Department of Health requires a special authorization form - **Authorization for Release of Confidential HIV Related Information**. The form is available as a PDF file at [www.nyu.edu/shc/medicalrecords](http://www.nyu.edu/shc/medicalrecords).

## COUNSELING RECORDS:

If you wish to obtain a copy of your counseling record, you must complete the form **Authorization for Release of Counseling Information**. The form is available as a PDF file under [www.nyu.edu/shc/medicalrecords](http://www.nyu.edu/shc/medicalrecords).

## WHERE TO SUBMIT COMPLETED FORMS:

You may visit the Health Information Management Services office and complete the necessary forms on-site or you may fax or mail your completed request form to our office. The fax number is (212) 443-1002.

**NYU Student Health Center**  
**Health Information Management Services**  
726 Broadway, Suite 340  
New York, NY 10003

Please allow 3-10 business days for processing of your request.

**Please be advised that we only fax medical records to  
healthcare providers in the event of a medical emergency.**

## FEES:

Health records will be sent to another healthcare provider free of charge as a professional courtesy. However, records not going directly to another healthcare provider are copied at the rate of 75 cents per page.

Students requesting that a copy of their health records be released directly to them will receive the first 20 pages free of charge, with each additional page copied at the rate of 75 cents per page.

Health records will be released upon payment of all fees.

**PLEASE NOTE:** HIMS will provide you with copies of radiology reports (written results of your x-rays). However, if you require copies of your radiology films, you must contact Radiology Services directly at (212) 443-1072.

When requesting health information, please be very specific to insure you receive the information you require. Also, please be advised that HIMS will process only fully completed Authorization for Release of Information forms, as required by federal law (HIPAA).

If you have any questions regarding the release of your health records (clinical and/or counseling), please contact the HIMS Correspondence Unit at (212) 443-1272.

### HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information

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 healthcare 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): _____ _____
AR 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.

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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The law protects you from HIV-related discrimination in housing employment healthcare 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:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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If any/all of these pages completed, please sign below

Signature \_\_\_\_\_ Date \_\_\_\_\_

Client/Patient Number \_\_\_\_\_