

# Authorization for Release of Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

**Please read the information below carefully before signing this form.**

I, or my authorized representative, request that health information regarding my care and treatment at New York University Student Health Center or \_\_\_\_\_ be released by NYU Student Health Center or \_\_\_\_\_ to the party named below.

Please be advised that if your health records contain information relating to HIV (Human Immunodeficiency Virus that causes AIDS), New York State requires a separate written authorization for release of this information. Please inform Health Information Management Staff if you need to sign the NYS authorization form.

**All 5 sections must be fully completed.**

1. Name of person whose information will be released (Please Print): \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Student/Employee I.D. #: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: ( \_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_ ) \_\_\_\_\_  
Daytime Evening

2. Name(s) and address(es) of person(s) who will be receiving this information:  
 \_\_\_\_\_  
 \_\_\_\_\_

**3. Reason for disclosure of information:**

- Follow-up Patient Care     New School     Insurance Issues     Individual's Request
- Other (please specify): \_\_\_\_\_

**4. Information to be used or disclosed (include dates where appropriate):**

**Please check all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> Allergy, Immunology & Travel Medicine Services<br><input type="checkbox"/> Complete Medical Record<br><input type="checkbox"/> Infectious Diseases ( <i>HIV/AIDS requires a New York State authorization form</i> )<br><input type="checkbox"/> Laboratory Results<br>Specify types: _____<br>_____<br>Dates: _____ | <input type="checkbox"/> Nutrition<br><input type="checkbox"/> Physical Exam (most recent)<br>Date: _____<br><input type="checkbox"/> Physical/Occupational Therapy<br>Dates: _____<br><input type="checkbox"/> Primary Care Services |
|--|---|

*Continued on Reverse Side*

Referral Forms to: \_\_\_\_\_

Dates: \_\_\_\_\_

Specialty Care Services

- Dermatology                       Optometry/Ophthalmology
- Ear, Nose & Throat             Orthopedics
- Endocrinology                     Podiatry
- Gastroenterology               Pulmonary
- Neurology                          Surgery

Urgent Care

Sports Physical

Women's Health Services

X-rays or other Diagnostic Reports

Specify types: \_\_\_\_\_ Dates: \_\_\_\_\_

X-ray Films

Dates: \_\_\_\_\_

**5. Date or event that will trigger the expiration of this authorization:**

- One time only     3 months     6 months     9 months     One Year     Other: \_\_\_\_\_

Specify event (must relate to patient or purpose for disclosure): \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to:

**NYU Student Health Center**  
**Manager, Health Information Management Services**  
 726 Broadway, Suite 334  
 New York, NY 10003

I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the information disclosed may be re-disclosed if the recipient(s) described in this form is not required by law to protect the privacy of the information, and the information is no longer protected by health information privacy rules.

**My questions about this form have been answered and the above required information has been completed.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Personal Representative, description of Representative's authority

**UPON REQUEST, THE PATIENT OR AUTHORIZED REPRESENTATIVE WILL BE PROVIDED  
WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.**

**Student Health Center Use Only:**

Date Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date Processed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Notations: \_\_\_\_\_

Name of Staff Member Processing This Request: \_\_\_\_\_