NYU | Student Health Center

# 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**.

**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**.

**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**.

**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 336
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 or health.hims@nyu.edu.

NYU | Student Health Center

# 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 unless there is a serious or imminent threat to the health and safety of you or others. 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 adress(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.***

❑ Allergy, Immunology & Travel Medicine Services

❑ Complete Medical Record

❑ Immunization Records ONLY

❑ Infectious Diseases ***(HIV/AIDS requires a New York State authorization form)***

❑ Laboratory Results

Specify types: ________________________

Dates: ________________________

❑ Nutrition

❑ Physical Exam (most recent)

Date: ________________________

❑ Physical/Occupational Therapy

Dates: ________________________

❑ Primary Care Services

*Continued on Reverse Side* ▶

**NYU Student Health Center | Health Information Management Services**
726 Broadway, 3rd Floor • New York, NY 10003-9580 • (212) 443-1272 • Fax: (212) 443-1002 • www.nyu.edu/health • health.hims@nyu.edu 3/23/15

- ❑ Referral Forms to: ______________________________

  Dates: ________________________________________

- ❑ Specialty Care Services
  - ❑ Dermatology
  - ❑ Ear, Nose & Throat
  - ❑ Endocrinology
  - ❑ Gastroenterology
  - ❑ Neurology
  - ❑ Optometry/Ophthalmology
  - ❑ Orthopedics
  - ❑ Podiatry
  - ❑ Pulmonary
  - ❑ 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): ________________________________________

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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 336
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: ______________________________________