5800713BU - Authorization for Release of Protected Health Information

Patient Name____

Date of Birth_____________________ SSN:_____________________________________

Patient Address

____

____

Telephone Number ____

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form.

I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8(a). In the event the Health Information described below includes any of these types of information, and I initial the line on the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Right at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
5. Name and address of health provider or entity to release this information:
   ❑ UHS
6. Name and address of person(s) or category of person to whom this information will be sent:
   ❑ Binghamton University Decker Center Student Health Center
7. Date information needed by/Appointment Date:______________________
   FAX: I DO/ DO NOT authorize that this Information be forwarded by FAX.
   If authorized FAX # ________________________

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8(a). Description of Information to be Released:
Date(s) of admission or outpatient visit Requested ________________________________
UHS Site or Physician: ____

❑ Abstract
❑ Discharge Summary
❑ Dental Radiographs
❑ Billing Records
❑ Speech/Language Pathology
❑ Initial Consults
❑ Conference Notes
❑ Pathology Report
❑ Radiology Report
❑ Medical Records from other Health Care Providers (patient care only)

❑ Admission History and Physical
❑ Operative Report
❑ Laboratory Reports**
❑ Physical Therapy Records
❑ Rehabilitation Nursing Reports
❑ Radiology Films
❑ Clinical Records
❑ Occupational Therapy Records

(Initial If Requested)
__ Genetic Testing
__ Alcohol/Drug Treatment
__ Neuropsychological Records
__ Psychiatric evaluation/record (mental health records)
__ HIV Related Information

8(b). ❑ By initialing here __________ (Initials) I authorize ______________________________ (Name of Individual) to discuss my health information with the person(s) listed here: ___________________________________.

9. Reason for Release of Information:
❑ At request of individual ❑ Other: ____

10. Date or event on which this authorization will expire: ____________________(If not completed, will expire in 365 days)

If not Patient, Name of Person Signing Form: (Qualified Requestor) ____

Relationship to Patient (Authority to sign on behalf of patient): ____

Signature of Patient (or Qualified Requestor):

____ Date: _____________ Time: ________

* Information from Mental Health Clinical Records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

LAB:

** NYSDOH does not allow patients to receive test results directly from the Laboratory unless authorized by the ordering provider.

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