NYU Langone HEALTH SYSTEM

Authorization for the Use & Disclosure of Protected Health Information (PHI) Instructions

1. Complete all sections on the form. Incomplete forms will not be accepted.
2. List the provider/entity(ies) from which you are requesting records and submit as noted in the chart below.
3. If Alcohol/Drug Treatment, Mental Health Treatment, Genetic Information, or Confidential HIV-related information is to be included, initial next to each appropriate type under number one.
   - Alcohol or Drug Treatment information means any information from an alcohol/drug treatment program.
   - Mental Health Treatment information means clinical records or clinical information tending to identify mental health patients, which is protected under New York State Law.
   - Confidential HIV-related information means any information that shows you had an HIV-related test, infection, or illness (including AIDS), or have been exposed to HIV. This includes negative results.
   - Genetic information means any laboratory test to diagnose the presence of a genetic variation linked to a predisposition to a genetic disease or disability, including DNA profile analysis.

An estimate of fees, if any, will be provided before the request is fulfilled.

Site	Address	Telephone Number
Tisch Hospital Rusk Rehabilitation Ambulatory Care Center	NYU Langone Medical Center HIM Department 650 First Avenue, 6th Floor NY, NY 10016	212-263-5490
NYU Hospital for Joint Diseases	Hospital for Joint Diseases HIM Department 301 E 17th Street, Room 200 NY, NY 10003	212-598-6790
Laura & Isaac Perlmutter Cancer Center	Perlmutter Cancer Center HIM Department 160 E 34th Street, 10th Floor NY, NY 10016	212-731-5096 (records) 646-754-1288 (radiology)
NYU Lutheran Medical Center	NYU Lutheran Medical Center HIM Department 150 55th Street Brooklyn, NY	718-630-7125
NYU School of Medicine Faculty Group Practices	Mail to the individual office directly	Contact the individual office directly
Lutheran Family Health Centers	Mail to the individual office directly	Contact the individual office directly
Lutheran Augustana	Associate Administrator, Augustana Center 5434 2nd Ave Brooklyn, NY 11220	718-630-6157
Lutheran Certified Home Health Agency	CHHA: Lutheran Care at Home 5407 2n Ave, Basement Level Brooklyn, NY 11220	718-630-6277
Lutheran Community Care Organization	5800 3rd Ave Brooklyn, NY 11220	718-630-7274
Southwest Brooklyn Dental Practice	Attn: Practice Manager 476 48th St, 3rd Floor, Brooklyn, NY 11220	347-377-5100

NYU LANGONE
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Patient Date of Birth	Telephone Number
Patient Address		

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

1. Information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING**, and/or **CONFIDENTIAL HIV*-RELATED INFORMATION** will not be shared unless I specifically give permission. By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form.

	Alcohol or Drug Treatment Information (records from alcohol/drug treatment programs)
	Mental Health Treatment Information (except psychotherapy notes which require a separate form)
	Genetic Testing Information
	HIV/AIDS-Related Information (release of this information must include the required statements regarding the prohibition of redisclosure when required by law)

2. Except for the special types of information listed above, information that is shared because of this authorization may be shared again by the recipient and no longer protected by federal or state law. Unless permitted by federal or state law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release 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 can revoke this authorization by writing to the provider/entity to whom I submitted the form (at the address listed on the instruction page). This revocation will be effective except to the extent NYU Langone has already relied upon this authorization.
4. Signing this authorization is voluntary. NYU Langone may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
5. If I am requesting radiology films, I understand that these are my original films and there are no film (analog) copies kept by NYU Langone. I am releasing NYU Langone from all responsibility for the maintenance of my imaging records.

Name and Address of the Provider/Entity from which you are requesting records (see instruction page)**:**

NYU LANGONE

Purpose for release of information:

☐At my request ☐Continuity of Care ☐Other (please explain):_____

Person receiving this information:

☐Self ☐Other (name; ID required for pick up): _____

Form/Format (fees may apply; an estimate will be provided prior to release)**:**

☐Mail paper to: _____

☐Pick up, paper ☐MyChart (available for download for 60 days)

☐Fax (number):_____ ☐CD/DVD

☐Secure Email (available to access/download for 30 days): _____

☐Other: _____

Description of the information to be released:

☐Entire medical record from the provider/entity indicated above

☐Records related to the following dates: _____

☐Radiology reports (list type of test and date):_____

☐Radiology films (list type of test and date):_____

☐Abstract (summary) of information related to the following dates: _____

☐Records sent to the provider/entity indicated above by non-NYU Langone providers and kept by NYU Langone for use in my care

☐Other (e.g., billing records; consent forms):_____

Authorization will end one (1) year from the date signed, unless stated here (specific event or date):
_____

My questions, if any, have been answered. In addition, I have been provided or offered a copy of this form if NYU Langone has asked me to complete this form.

Signature: _____ Date: _____ Time: _____ AM/PM
(Patient or person authorized to sign)
If the person consenting is not the patient, print name and type of authority to sign.
Supporting documentation should be provided at the time of the request.

Name/Authority: _____

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonable could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Office Use Only: MRN: _____Received: _____/_____/_____ Initials: _____