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: _____