NYU Langone Health

Authorization to Share PHI for Billing and Payment Purposes Only

Patients of NYU Langone Health may wish to have someone be able to obtain billing and payment information on their behalf.

By listing an individual below ("recipient"), you are giving NYU Langone Health permission to provide the limited information, as described below, to the recipient should they call, send an electronic message, or request billing documentation on your behalf. The recipient will need to provide your identifying information as well as his/her name to receive this information. Parents or legal guardians of minor children are **not** required to complete this form to obtain information about their child/patient.

You do not have to complete this form if you do not want to share your billing information. You may change your mind at any time and revoke (take back) your permission to share billing and payment-related information with the individuals you have listed. To revoke this permission, contact our customer service department at **877-648-2964** or you can email us at **NYUPatientBilling@nyulangone.org**.

The individuals listed below are authorized to receive my protected health information, or PHI, on my behalf as it specifically relates to any NYU Langone Health/NYU School of Medicine Faculty Group Practice bill or to facilitate payment. This could include my name, date of birth, date of service (the date I had an appointment), the provider's name, service location, insurance information, and CPT (current procedural terminology, or service billing code) codes.

Information relating to **ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT, GENETIC TESTING, and/or CONFIDENTIAL HIV*-RELATED INFORMATION may be shared unless I specifically decline permission.** By placing my initials below, I specifically decline 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 may require additional authorization)
	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)

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.

By listing an individual below, I also understand that given the information related to billing, the recipient may be able to infer additional information about my health and/or treatment services provided by NYU Langone Health.

Please print the name(s) of the individuals below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **I do not wish to share my information with anyone.**

You may request a copy of your completed form.

Patient (Your) Name (please print): _____ Date:_____

Patient Signature: _____

Authorization will end five (5) years from the date signed, unless stated here (specific event or date):

Date: _____