



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, Kimmel, Hassenfeld Children's Hospital, Rusk Rehabilitation, Ambulatory Care Center | NYU Langone Health HIM Department in person: 550 First Avenue, Lobby, NY, NY 10016 mail: One Park Avenue, 3 rd Floor, NY, NY 10016 | 212-263-5490 |
| NYU Langone Orthopedic Hospital | NYU Langone Orthopedic Hospital HIM Department in person: 380 2 nd Avenue, Suite 640 NY, NY 10003 mail: 301 E 17 th St, NY, NY 10003 | 212-598-6790 |
| NYU Langone Hospital – Long Island | NYU Langone Hospital – Long Island HIM Department in person: Admitting Office-Main Lobby 259 First Street, Mineola, NY 11501 mail: 200 Old Country Road, Suite 201 Mineola, NY 11501 | 516-663-2515, option 4 |
| NYU Langone Hospital – Long Island - Laura & Isaac Perlmutter Cancer Center | Perlmutter Cancer Center HIM Department 120 Mineola Blvd, 6 th Floor Mineola, NY 11501 | 516-633-8250 |
| NYU Langone Hospital-Brooklyn | NYU Langone Hospital-Brooklyn HIM Department 150 55 th Street Brooklyn, NY 11220 | 718-630-7125 |
| NYU Grossman School of Medicine Faculty Group Practices (FGP) | To the individual office directly | Contact the individual office directly |
| Family Health Centers at NYU Langone | Marilyn Vientos, Director FHC Network Operations FHCPatientRelations@nyulangone.org | Contact the individual office directly |
| NYU Langone Hospital – Long Island Certified Home Health Agency (CHHA) | NYU Langone Hospital – Long Island - CHHA 290 Old Country Road Mineola, NY 11501 | 516-663-8000 |
| Southwest Brooklyn Dental Practice | Attn: Practice Manager 215 54 th Street Brooklyn, NY 11220 | 929-455-2099 |
| Radiology Films/Images | Tisch: 560 1 st Ave, 2 nd Floor, NY, NY 10006 Orthopedic Hospital: 301 East 17 th St, Suite 600/6 th Floor, NY, NY 10003 FGP Radiology: NYU Langone Health Radiology Medical Records, 650 First Avenue, 4 th Floor, NY, NY 10016 All other locations: directly to the location of the imaging study | Tisch: 212-263-5227 Orthopedic: 212-598-6373 FGP: 212-263-7108 Others: contact the individual office directly |

**NYU LANGONE HEALTH
 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.

| | |
|--------------------------|--|
| <input type="checkbox"/> | Alcohol or Drug Treatment Information (records from alcohol/drug treatment programs) |
| <input type="checkbox"/> | Mental Health Treatment Information (except psychotherapy notes which may require additional authorization) |
| <input type="checkbox"/> | Genetic Testing Information |
| <input type="checkbox"/> | 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 Health has already relied upon this authorization.
4. Signing this authorization is voluntary. NYU Langone Health 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 original radiology films, I understand that there are no film (analog) copies kept by NYU Langone Health. I am releasing NYU Langone Health from all responsibility for the maintenance of my imaging records.

Name and address of the Provider/Entity who you want to release information (see instruction page):

NYU LANGONE HEALTH

Purpose for release of information:

- At my request Continuity of Care
- Other (please explain, including if for a government benefit or program): _____

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 USB
- 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/images (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 Health providers and kept by NYU Langone Health 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 Health 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: _____