NYU LANGONE MEDICAL CENTER
NYU Hospitals Center and NYU School Of Medicine
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Under federal and state law, we need your written authorization before we share your protected health information (PHI). Please read the information below carefully before signing this form. ***All fields must be completed.***

Patient Name	Date of Birth	Phone Number
Address		

I, or my authorized representative, hereby authorize NYU Langone Medical Center to share my PHI.
I understand that:

1. Information relating to **ALCOHOL/DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING**, and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will not be shared unless I specifically give permission by placing my initials in the appropriate space(s) on page 2.
2. Except for HIV information, 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 use 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 at any time by providing a written notice of revocation to the department at the address listed below for submission of this form. This revocation will be effective except to the extent NYU Langone Medical Center has already relied upon this authorization.
4. Signing this authorization is voluntary. NYU Langone Medical Center 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.

Indicate which Provider/Entity from which you are requesting records:

Check Below	Provider/Entity Releasing the Information	Contact Phone Number	Submit the form in person or mail to the address below:
☐	Tisch Hospital, Rusk Institute, Ambulatory Care Center	212-263-5490	NYU Langone Medical Center HIM Department 650 First Avenue, 6th Floor, NY, NY 10016
☐	Hospital for Joint Diseases	212-598-6790	Hospital for Joint Diseases HIM Department 301 E 17th Street, Room 200, NY, NY 10003
☐	NYU School of Medicine Student Health Service	212-263-5489	NYU School of Medicine Student Health 334 East 25th Street, Suite 103, NY, NY 10010
☐			

(Rev. 10/16)

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Purpose for release of information (check box below; pursuant to NYS law, fees may apply)**:**

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

Format (check box below):

☐ Paper
☐ Electronic

Description of information being released (check box below):

☐ An abstract (summary of relevant information) for the following date(s):

_____

☐ All records related to the following date(s):

_____

☐ Other (specify): _____

Include information relating to (initial beside each applicable category)**:**

	Alcohol or Drug Treatment
	Mental Health Treatment
	Genetic Testing Information
	Psychotherapy Notes (If yes, please complete the additional authorization form for this purpose)
	HIV-Related information (If yes, please complete an official NYSDOH HIV release form)

Person receiving this information:

☐ Send to:

Name:	Address (physical or email): Fax Number (if applicable):

☐ I will pick it up
☐ My personal representative (name) _____ will pick it up.
(***identification required for pick-up***)

Authorization will end in one (1) year unless the information is completed below:

☐ Specific event or date (specify): _____

All items on this form have been completed and my questions have been answered. In addition, I have been provided a copy of this form.

Signature: _____ Date: _____ Time: _____ AM/PM
(Patient or person authorized to sign)

If the consenting party is other than the patient, print name and relationship to patient. Supporting documentation should be provided at the time of the request.

Name/Relationship:_____

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

(Rev. 10/16)