NYU Langone Medical Center
Trinity Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical Records Department
NYU Trinity Center
111 Broadway 2nd FL, New York, NY 10006
Phone (212) 263-9700 Fax (212) 263-9701

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

I, or my authorized representative, request(s) that medical information regarding my care and treatment at NYU Trinity Center be released to the party named below.

I understand that this authorization may include disclosure of information relating to **ALCOHOL or DRUG ABUSE, GENETIC TESTING, PSYCHIATRIC CARE** and/or **CONFIDENTIAL HIV* RELATED INFORMATION.** In the event the medical information described below includes any of these types of information, I specifically authorize release of such information to the person(s) indicated below. I also understand that I have the right to cancel this release at any time.

I understand that if I am authorizing the release of HIV related information, the recipient(s) is prohibited from redisclosing such information without my authorization, unless permitted to do so under federal or state law. I understand that I have right to request a list of people who may receive or use my 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 rights.

There is no fee if the records are being released to a Physician. I understand that the practice will charge me $0.75 per page copying fee if the records are going to the patient. In addition, there is a $150.00 fee for records requested by a legal office or insurance company.

Please Print **Medical Record #**

Name of patient whose information will be released:	Date of birth: SS#
Name and address of person signing this form (patient or personal representative):	
Relationship to patient whose information will be released (if not the patient):	
Name(s) or category of person(s) at Hospital who will disclose this information (e.g., Medical Records Department):	
Name and address of person(s) or category of persons who will be given this information:	
Specific information to be released:	Include HIV Related Information: Yes_ No_
Reason for release of information:	
This is a one-time authorization for release of information within 60 days (check) ___; **OR** The date or event that will trigger the expiration of this authorization (please specify):___________________________________	

My questions about this form have been answered and the required information has been completed above. I know that I do not have to allow release of medical information and that I can change my mind and revoke this authorization at any time, except to the extent that the hospital has already taken action based on this authorization.

____ _________________
Signature of Authorized Representative Date

*Human Immunodeficiency Virus that causes AIDS.

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED