



at Trinity Center

Sending Protected Health Information

I understand that I have the right to determine how Dr. Carron at NYU Medical at Trinity Center sends my protected health information, including test results and HIV-related information to third parties such as other physicians, other health care providers, hospitals or testing services.

I hereby authorize Dr. Carron to send my protected health information in the following way(s) (check all that you authorize):

- By letter sent via USPS
- By phone*
- By email*
- By fax*
- Other
(specify): _____

**Remember, Dr. Carron cannot protect your medical information from unintentional disclosure if you authorize them to communicate by fax, e-mail or phone. We do, however, use a secure messaging system to send protected health information to you.*

My questions about this form have been answered. I know that I can change my mind at any time and revoke this authorization by writing to Dr. Carron at NYU Medical at Trinity Center.

I know that I have released Dr. Carron and NYU Medical at Trinity Center from any liability that may arise from any resulting inadvertent disclosure of my medical information as a result of any non-public or non-secure methods of transmittal that I have selected.

Signature of Patient (or legally-authorized representative)

Date

If legal representative, indicate relationship to patient: _____

Print Name