



Individual Authorization

Individual Authorizing the Use or Disclosure of Information.

Patient: _____

Address: _____

Telephone: _____ Date of birth: _____

Social Security Number: _____

Please read and complete the following statements carefully.

Psychotherapy Notes and HIV-Related Information

- Ⓒ Check if this authorization is for psychotherapy notes.
- Ⓒ Check if this authorization is for HIV-related information

If this authorization is for psychotherapy notes, it may *not be* used as an authorization for any other type of protected health information. If this authorization is for confidential HIV-related information, you must also sign a separate written authorization to meet New York State requirements for the release of such information.

We will not condition treatment or payment activities in connection with your treatment on you giving this authorization.

By signing this authorization form, you authorize _____ to use or disclose your protected health information as described below. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Protected Health Information to Be Used and/or Disclosed: Specifically describe the protected health information you authorize us to use or disclose for the purposes stated below:

Entities Who Will Use or Receive the Information: The persons and/or organizations (or the classes of persons and/or organizations) to whom you authorize disclosure of the protected health information described above are:

Purpose of this Authorization: Describe the purposes for which your protected health information will be used or disclosed:

Expiration: The date or event that will trigger the expiration of this authorization (you must select one).

- One Time Request Ten Years
 One Year Other _____
 Five Years

Right to Revoke: If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write directly to the physician's office where you granted your authorization.

SIGNATURE

You have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

I have read this form. By signing below, I acknowledge that I have read and accepted all of the above.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Personal Representative's Authority to Act _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

You can fax the completed form to (212) 263-9701 or mail it to our office at:

NYU Trinity Centre
Attn: Medical Records
111 Broadway, 2nd Floor
New York, NY 10006