COLUMBIA | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
STUDENT HEALTH ON HAVEN
Location: 100 Haven Avenue, Suite 230 New York, NY 10032
Phone: (212) 305-3400 Fax: (212) 342-3955
Email: studenthealthonhaven@cumc.columbia.edu
Mailing Address: Student Health on Haven, 630 W. 168th St., Mailbox 77, New York, NY 10032

Authorization for Release of Medical Information

Patient Name:_____ DOB:_____ MRN:_____
Phone:_____ UNI:_____ C: Number:_____
Patient Address:_____ Email: _____
_____

Please check one of the boxes below.

□ I authorize Student Health on Haven to **release information to**:	□ I authorize Student Health on Haven to **obtain information from***:
_____ Name of Provider/Facility	_____ Name of Provider/Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone # / Fax # (include area code)	_____ Phone # / Fax # (include area code) ***IF REQUESTING RECORDS FROM NYP WORKFORCE HEALTH & SAFETY, YOU MUST PROVIDE A COPY OF YOUR PHOTO ID**

TYPE OF RECORDS REQUESTED: (Check all that apply)

□ **Pertinent chart notes, and most recent physical or Routine GYN** (circle which) **will be printed. Laboratory results & immunization history will be posted to the web portal.**

□ Immunization record □ Laboratory reports □ Other studies (please specify):_____
□ Pap smear results □ X-ray reports (only if ordered by SHS)
□ Mental Health Records ____ □ Substance Use treatment ____ □ HIV Results/Information (HIV release form signed)____
(Initial) **(Initial)** **(Initial)**

□ All medical records relating to a specific illness or injury. (Specify illness and dates)
_____

□ Other (please specify) _____
PURPOSE FOR THIS REQUEST: _____

AUTHORIZATION VALID FOR: (Check one)

□ This request only.
□ This request and medical records of any future treatment of the type(s) described above will expire one year after date of request.

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released.
- I also understand that this authorization expires in one year from the date of request if not otherwise specified.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure.
- All Information released will be reviewed prior to release.
- The above information will not be given, sold, transferred, or in any way related to any other person not specified in the consent form without first obtaining my additional written consent.
- Release of HIV-related information also requires a NYSDOH Release of information authorization. (NYS DOH-2557)
- A copy of this signed form will be provided to me and a copy placed in my chart.

_____
Signature of Patient Date

For Student Health use only

Chart Reviewed: □ OK to release requested records □ Labs on portal □ Further review required **Initial_____ Date _____**

Requested Records Copied: Init_____ Date_____Invoice sent: □ N/A **Initial_____ Date _____**

Requested Records: □ Mailed □ Faxed □ Left for pick up(patient notified records available) **Initial_____ Date_____**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request 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 have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY, GOVERNMENTAL AGENCY OR OTHER SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- □ **Pertinent Chart Notes**
- □ Medical Record from (insert date)_____ to (insert date)_____
- □ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- □ Other:_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here_____ I authorize _____
Initials Name of individual health care provider

to discuss my health information with my attorney, governmental agency, or other listed here:

_____
(Attorney/Firm or Governmental Agency/Other Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

_____ Date: _____
Signature of Patient or representative authorized by law.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having**

HIV symptoms or infection and information regarding a person's contacts.