NYU Langone Health

Authorization for the Use & Disclosure of Protected Health Information (PHI) Instructions

1. Complete all sections on the form. Incomplete forms will not be accepted.
2. List the provider/entity(ies) from which you are requesting records and submit as noted in the chart below.
3. If Alcohol/Drug Treatment, Mental Health Treatment, Genetic Information, or Confidential HIV-related information is to be included, initial next to each appropriate type under number one.
   - Alcohol or Drug Treatment information means any information from an alcohol/drug treatment program.
   - Mental Health Treatment information means clinical records or clinical information tending to identify mental health patients, which is protected under New York State Law.
   - Confidential HIV-related information means any information that shows you had an HIV-related test, infection, or illness (including AIDS), or have been exposed to HIV. This includes negative results.
   - Genetic information means any laboratory test to diagnose the presence of a genetic variation linked to a predisposition to a genetic disease or disability, including DNA profile analysis.

An estimate of fees, if any, will be provided before the request is fulfilled.

Site	Address	Telephone Number
Tisch, Kimmel, Hassenfeld Children's Hospital, Rusk Rehabilitation, Ambulatory Care Center	NYU Langone Health HIM Department 650 First Avenue, 6th Floor NY, NY 10016	212-263-5490
NYU Langone Orthopedic Hospital	NYU Langone Orthopedic Hospital HIM Department in person: 380 2nd Avenue, Suite 640 NY, NY 10003 mail: 301 E 17th St, NY, NY 10003	212-598-6790
NYU Winthrop Hospital	NYU Winthrop Hospital HIM Department 200 Old Country Road, Suite 580 Mineola, NY 11501	516-663-2515, option 4
Laura & Isaac Perlmutter Cancer Center	Perlmutter Cancer Center HIM Department 160 E 34th Street NY, NY 10016	212-731-6180
NYU Langone Hospital-Brooklyn	NYU Langone Hospital-Brooklyn HIM Department 150 55th Street Brooklyn, NY 11220	718-630-7125
NYU School of Medicine Faculty Group Practices (FGP)	To the individual office directly	Contact the individual office directly
Family Health Centers at NYU Langone	To the individual office directly	Contact the individual office directly
NYU Winthrop Certified Home Health Agency (CHHA)	NYU Winthrop CHHA 290 Old Country Road Mineola, NY 11501	516-663-8000
Southwest Brooklyn Dental Practice	Attn: Practice Manager 215 54th Street Brooklyn, NY 11220	929-455-2099
Radiology Films/Images	Tisch: 560 1st Ave, 2nd Floor, NY, NY 10006 Orthopedic Hospital: 301 East 17th St, Suite 600/6th Floor, NY, NY 10003 FGP Radiology: NYU Langone Health Radiology Medical Records, 650 First Avenue, 4th Floor, NY, NY 10016 All other locations: directly to the location of the imaging study	Tisch: 212-263-5227 Orthopedic: 212-598-6373 FGP: 212-263-7108 Others: contact the individual office directly

NYU LANGONE HEALTH
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Patient Date of Birth	Telephone Number
Patient Address		

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

1. Information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING**, and/or **CONFIDENTIAL HIV*-RELATED INFORMATION** will not be shared unless I specifically give permission. By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form.

	Alcohol or Drug Treatment Information (records from alcohol/drug treatment programs)
	Mental Health Treatment Information (except psychotherapy notes which may require additional authorization)
	Genetic Testing Information
	HIV/AIDS-Related Information (release of this information must include the required statements regarding the prohibition of redisclosure when required by law)

2. Except for the special types of information listed above, 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 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 can revoke this authorization by writing to the provider/entity to whom I submitted the form (at the address listed on the instruction page). This revocation will be effective except to the extent NYU Langone Health has already relied upon this authorization.
4. Signing this authorization is voluntary. NYU Langone Health 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.
5. If I am requesting original radiology films, I understand that there are no film (analog) copies kept by NYU Langone Health. I am releasing NYU Langone Health from all responsibility for the maintenance of my imaging records.

Name and address of the Provider/Entity who you want to release information (see instruction page)**:**

NYU LANGONE HEALTH

Purpose for release of information:

☐At my request ☐Continuity of Care

☐Other (please explain, including if for a government benefit or program):_____

Person receiving this information:

☐Self ☐Other (name; ID required for pick up): _____

Form/Format (fees may apply; an estimate will be provided prior to release)**:**

☐Mail paper to: _____

☐Pick up, paper ☐MyChart (available for download for 60 days)

☐Fax (number):_____ ☐CD/DVD ☐USB

☐Secure Email (available to access/download for 30 days): _____

☐Other: _____

Description of the information to be released:

☐Entire medical record from the provider/entity indicated above

☐Records related to the following dates: _____

☐Radiology reports (list type of test and date):_____

☐Radiology films/images (list type of test and date):_____

☐Abstract (summary) of information related to the following dates: _____

☐Records sent to the provider/entity indicated above by non-NYU Langone Health providers and kept by NYU Langone Health for use in my care

☐Other (e.g., billing records; consent forms):_____

Authorization will end one (1) year from the date signed, unless stated here (specific event or date):

_____

My questions, if any, have been answered. In addition, I have been provided or offered a copy of this form if NYU Langone Health has asked me to complete this form.

Signature: _____ Date: _____ Time: _____ AM/PM

(Patient or person authorized to sign)

If the person consenting is not the patient, print name and type of authority to sign.
Supporting documentation should be provided at the time of the request.

Name/Authority: _____

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonable could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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