

Office of International Student and Scholar Services
Binghamton University
State University of New York

AUTHORIZATION for HEALTH CARE / HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and the Office of International Student and Scholar Services is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, the ISSS will not use your PHI to advocate on your behalf with respect to health care or health insurance matters UNLESS you sign this form permitting the ISSS to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing. If you have any questions regarding what is set forth on this document, please contact Binghamton University's compliance official at 607-777-3734 or the State University Privacy Officer at privacy@sunyadm.suny.edu.

Patient Name: _____ B #: _____

Address: _____

DOB: _____ Telephone #: _____ E-Mail _____

I hereby authorize representatives of the ISSS to release information related to my medical care for the specified date(s) or type(s) of service to the specified insurer(s) and/or provider(s):

Date(s) and/or Type(s) of Service:

- Health care for or on the following date(s) only: _____
 All health care provided
 Health care for specified condition/treatment: _____

Providers:

- All health care providers (including physicians and hospitals)
 Health care from the following provider(s) only: _____
Please specify individual provider(s)

Insurers:

- The specified health care insurers and/or HMOs: _____
Please specify individual insurer(s) and/or HMO(s)

By providing this authorization, I give permission for representatives of SUNY to discuss the medical care that I received from the above named providers, during the time period listed, as well as the actual or requested payment for such care, with both the providers and insurers listed above. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications. If not earlier rescinded by me, this authorization shall expire *one year from today's date*: _____
(specify expiration date)

Print Name of Patient (or Personal Representative¹)

Signature of Patient (or Personal Representative¹)

Date

¹ As defined in 45 CRF §164.502(g)