BINGHAMTON UNIVERSITY
UNIVERSITY HEALTH SERVICE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name_________________________________**Date of Birth**___________________**SS#**____________________
(please print)

I hereby authorize the Binghamton University Health Service to disclose the following information from my health record:

Information to be released to:

Name____

Address____**Phone**______________**Fax**________________

Date(s) of health care authorized for release:____

Nature of information to be released:____
(Records pertaining to HIV tests or discussions or alcohol/drug treatment require separate authorization forms)

I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date or 6 months from the date of the request if no date is specified: **Expiration Date:** ________________________.

I understand that authorizing the disclosure of my health information is voluntary and not a condition for treatment. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

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Patient Signature ____Date: ______________________________

There is a ten-dollar ($10.00) fee for faxing health records. Make check payable to Binghamton University/Health Services.
Please allow one week for the processing of your request.

Mail check to:
Binghamton University/ Health Services
P.O. Box 6000
Binghamton NY 13902-6000

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