

SYRACUSE UNIVERSITY HEALTH SERVICES

111 Waverly Avenue, Syracuse, NY 13244-2320

Phone: (315) 443-2666 Fax: (315) 443-9010

Chart #: _____

AUTHORIZATION

For the Use and Disclosure of Protected Health Information

Purpose: This form will authorize Syracuse University Health Services (“Health Services”) to disclose your protected health information (“PHI”) *for a specific date of service or condition-specific, time-limited health condition* (not to obtain future medical records or itemized statements) to the individual or entity named below. This authorization form is voluntary; Health Services will not condition your treatment on the signing of this authorization form.

Please Complete the Following Information

1. Individual Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SU ID#: _____

2. Individual or Entity Authorized to Receive PHI: Please provide the name and address of the Individual or Entity to whom you are authorizing Health Services to disclose your PHI:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. Description of PHI to be Disclosed: Please indicate the specific PHI to be disclosed (i.e., lab results; x-ray reports; entire medical record; specific dates of service; etc.):

4. Reason for Disclosure: Please indicate the reason for the disclosure of the above stated PHI:

5. Expiration: This authorization shall become effective immediately, and unless otherwise revoked, shall expire on:

(Indicate date or event on which the authorization shall expire)

(Continued on reverse side)

Right to Revoke Authorization. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that Health Services has already relied upon this authorization. I understand that in order to revoke this authorization my revocation must be submitted in writing to: Privacy Official, Syracuse University Health Services, 111 Waverly Avenue, Syracuse, NY 13244-2320.

Redisclosure: I understand that when my PHI is disclosed pursuant to this authorization it may be subject to redisclosure by the individual or entity receiving the PHI and may no longer be protected by the federal HIPAA privacy regulations.

Dated: _____, 20____.

Signature of Individual

Printed Name of Individual

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

Signature of Personal Representative

Printed Name of Personal Representative

Description of authority: _____
(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, power of attorney)

[For Use by Syracuse University Health Services Only]

Verification of Personal Identity: _____ By Whom: _____

Date Request Received: _____ By Whom: _____

Date PHI Disclosed: _____ By Whom: _____

Approved by Privacy Official/Designee: _____ Date: _____

Reason for Denial of Access (if applicable): _____

Date Transmitted: _____ By Whom: _____

Date Information Received: _____ By Whom: _____

(Copy of signed Authorization to be provided to Individual or Personal Representative)