Plattsburgh State

Authorization for Use or Disclosure of Protected Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

Section A: Must be completed for all authorizations

Name: ____ ID Number: __________________ Date of Birth: ___/___/_____

Authorizes:

____
Name of Health Care Provider

____
Person or class of persons

Release Protected Health Information to:

____
Name of Health Care Provider/Plan/Other

____
Person or class of persons

Specific description of information:

_____ 1. Only those records regarding treatment for the following medical condition or injury:___________________________
____

_____ 3. Only those records that contain the following specified information: ____
____
____

_____ 4. Records containing information relating to treatment for alcohol or substance abuse. Initials: ______

_____ 5. Records containing information relating to treatment for mental health. Initials: ______

_____ 5. Records for the period from ______________ to _____________
Date Date

Specific purpose for use or disclosure: ____
____

Expiration Date or Event: ____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

1. Will the health care plan or provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the information? Yes_____ No_____
2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
3. I understand that I may see and copy the information described on this form if I request it, and that I will receive a copy of this form after I sign it.

Signature:___________________________ Date:_______________

- You have the right to revoke this authorization at any time, except to the extent that Plattsburgh State University has already taken action based upon your authorizations. To revoke this authorization write to: Plattsburgh State Privacy Officer, 101 Broad Street, Plattsburgh, NY 12901.
- This information may be disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information and the information is no longer protected by federal privacy regulations.
- Releases of HIV-related information must be authorized on a separate form, *Authorization for Release of Confidential HIV Related* Information.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

____
Signature of Individual or Personal Representative

____
Date

____
Print Name of Individual or Personal Representative

____
Description of Personal Representative's Authority