BARNARD
Primary Care Health Service

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Primary Care Health Service
Lower Level Brooks Hall
3009 Broadway, New York, NY 10027
Phone: 212-854-2091 Fax: 212-854-2702

For office use only
[ ] Mailed (date) ___/___/___/ Initial ____
[ ] Faxed (date) ___/___/___/ Initial ____
[ ] Left at Reception Desk (date) ___/___/___/ Initial ____

Authorization to Release Medical Records

This form provides the authorization necessary for the release of your protected health information and is compliant with the Family Educational Rights and Privacy Act of 1974. Please print legibly in black ink. Fax or mail this form, or bring it to our office. We cannot accept it via email for privacy and security reasons. Processing times vary depending on the materials you request.

Full Name: _____ Last Four Digits of SS #: _____ DOB: ___/____/_____

Cell phone: _____ **Email: _____ Graduation Year: _____**

☐ **Check here if you will return to pick-up records**

Authorizes Release of Protected Health Information

☐ From: **Barnard College Primary Care Health Service**

To: (Name & Fax # **OR** Name & Address)
_____
_____
_____

☐ From: **Another Provider**
_____
_____
_____

To: **Barnard College Primary Care Health Service**

Specific Description of Information (choose one):

☐ Immunization Records
☐ All Records from Dates ____/____/____ to ____/____/____
☐ Records Containing the Following Specified Information: _____
☐ I hereby give consent for the release of any HIV-related information that may be in my medical records only to the person(s)/clinic(s) listed above.

Charges for medical records: Current students no charge; Alumnae/previous students: $0.75/per page
Each additional U.S. fax # or address, add $1.00; International fax # or international address add $2.00

_____ ____/____ _____ _____
Visa or MasterCard (circle one) **Exp. Date** **CID (3 digits on back of card)** **Billing Zip Code**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Manager of the Barnard College Primary Care Health Service, except to the extent that Barnard College has already taken action based upon my authorizations. Unless otherwise revoked, this authorization will expire 6 months from date of signature. A copy of this form is available to me upon my request. *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.*

_____ Date: ____/____/_____
Signature of Individual

_____
Printed Name