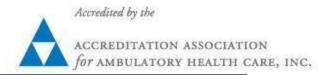


AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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.

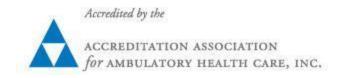
Please print. Incomplete forms will not be prod	cessed. See Page 3 for instructions and fees
1. PATIENT WHOSE INFORMATION IS TO BE RE	ELEASED
Full Name:	DOB:/
Full Name:	Maiden/Other Graduation Year:
2. PERSON/ORGANIZATION WHO IS RECEIVING	OR RELEASING INFORMATION
I authorize Barnard College Primary Care to:	Name/Facility
Release health information to OR Obtain health information from *select only one*	Address City/State/Zip Phone Number Fax Number OR Email
3. TYPE OF INFORMATION TO BE RELEASED	
 Office Visit Notes (includes Primary Care, Preventive Gynecology Notes Laboratory Immunizations Other (please specify): 	
4. DATES OF INFORMATION TO BE RELEASED	
Information released will fall within this date range: to Month/Day/Year Month/Day/Year	Future dates of service will not be honored.
5. METHOD OF RELEASE	
Information will be released by: _ Mail _ Fax _ Pick	c-Up _ Verbal/Phone _ Email *select only one*
6. PURPOSE OF RELEASE	
Personal Use Continued health care Academi Other (specify):	cs _ Employment _ Legal
7. PATIENT RIGHTS AND SIGNATURE	
I understand that the information in my health record may in (STI), acquired immunodeficiency syndrome (AIDS), or hum authorization is valid for 60 days , unless revoked by my writt the above designated information. I understand that authorizing refuse to sign this authorization. I need not sign this form in ord for record copies. I understand that any disclosure of infor re-disclosure and the information may not be protected by fede release, I understand that email is not a secure form of com transmission or misdirected. I understand that the choice to have If I have questions about the disclosure of my health information,	an immunodeficiency virus (HIV). I understand that this sen notice, provided said notice is received prior to release of a the disclosure of this health information is voluntary. I can ler to receive treatment. I understand there may be a charge rmation carries with it the potential for an unauthorized and confidentiality rules. If I selected email as the method of imunication as email communication can be intercepted in a my protected health information emailed is at my own risk.





Each additional U.S. fax # or addre	- ·		ous students: \$0.75/pe international address	
Visa or MasterCard (circle one) Code	Exp. Date	CID (3 di	gits on back of card)	Billing Zip
I understand that I have the right to revoke this writing and present my written revocation to th Barnard College has already taken action based months from date of signature. A copy of this for about this form have been answered. By signing	e Manager of the Barnard Co upon my authorizations. Un rm is available to me upon r	ollege Primary Car less otherwise rev ny request. <i>I have</i>	re Health Service, except to to voked, this authorization will e read this form and all of m	the extent that expire 6
		•		
			Legal Relations	hip
		e patient)	Legal Relations	hip
(**paperwork must be submitted with	this request) (if not the	e patient) JSE		hip
ONLY Patient unable to sign:	FOR OFFICE Continuous Telephone	e patient) USE Consent	Other:	hip
	FOR OFFICE Continuous Telephone	e consent _	Other:	hip
ONLY Patient unable to sign:	FOR OFFICE Legions Telephone Date	e consent	Other: Staff Initials	hip





INSTRUCTIONS

All sections must be completed in their entirety.

- 1. Patient Information: Complete the entire section to clearly and legibly identify patient - entire patient name (and any previous names), date of birth and phone number.
- 2. **Receiving Party**: Identify the full name/organization, address, phone and fax number of the recipient of your health information. Please allow 7-10 days for processing.
 - Select only one: Do you want to PCHS to release information? **OR** Do you want PCHS to obtain information?
 - If the requested release will be made by mail, provide the complete address.
 - If the requested release will be made by fax, provide the fax number.
 - If the requested release will be made by email, please provide the email address.
- 3. **Information to be Released**: Be as specific as possible about the information you need released. For example, types of visits or the name of the physician or provider who treated you.
- 4. Dates to be Released: This can be a very specific date or more general. For example, July 15, 2012 or June 2012 - Feb 2013. You may not request future dates of service. For example, if you complete this form on June 1, 2030, you may not authorize the release of progress notes from an appointment that is scheduled on June 30, 2030.
- 5. **Method of Release:** How will your information be delivered? Select **only one** method and be sure to provide address, fax number or email address in section number 2 (see above).
- 6. **Purpose of Release:** Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).
- 7. **Rights/Signature:** Your **handwritten** signature and date of form completion are required.