BARNARD
Primary Care Health Services

Accredited by
Accreditation Association
for Ambulatory Health Care, Inc.

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.

PATIENT FULL NAME: _____ **DOB:** ____/____/____

CELL: _____ **CURRENT STUDENT?** ☐ **YES** ☐ **NO**

EMAIL: _____ **GRADUATION YEAR:** _____

I, THE UNDERSIGNED, REQUEST AND AUTHORIZE: BARNARD COLLEGE – PRIMARY CARE HEALTH SERVICE
3009 BROADWAY, NEW YORK, NY 10027
TEL: 212-854-2091 FAX: 212-854-2702

☐ **TO RELEASE MY MEDICAL RECORDS TO MYSELF**

☐ **TO RELEASE MY MEDICAL RECORDS TO:**

☐ **TO REQUEST MY MEDICAL RECORDS FROM:**

DOCTOR'S OR FACILITY NAME: _____

ADDRESS: _____

TEL: _____ **FAX:** _____

TYPE OF INFORMATION TO BE RELEASED:

☐ **OFFICE VISIT NOTES** ☐ **LIST OF ALLERGIES**

☐ **IMMUNIZATION RECORDS** ☐ **MEDICATION LIST**

☐ **LAB RESULTS** ☐ **GYNECOLOGY NOTES**

☐ **OTHER (PLEASE SPECIFY):** _____

DATES OF INFORMATION TO BE RELEASED:

_____ TO _____
Month/Day/Year Month/Day/Year

PURPOSE OF RELEASE:

☐ **PERSONAL USE** ☐ **CONTINUED HEALTH CARE** ☐ **ACADEMICS** ☐ **EMPLOYMENT**

☐ **OTHER (SPECIFY):** _____

DELIVER VIA: ☐ **FAX** ☐ **MAIL** ☐ **PICK UP** ***select only one***

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PATIENT RIGHTS AND SIGNATURE

I understand that the information in my health record may include information relating to sexually transmitted infections (STI), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that this authorization is **valid for 60 days**, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand there may be a charge for record copies. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact the Primary Care Health Services Office.

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**	**Security Code**	**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.*

_____	_____	_____
Signature of Patient or Legal Representative**	Date	Legal Relationship

(if not the patient, paperwork must be submitted with this request)**

****OFFICE USE ONLY****

Patient unable to sign: ☐ **Minor** ☐ **Telephone Consent** ☐ **Other:** _____

Request received in PCHS on _____ (Date) by _____ (PCHS Staff Initials)

Request _____ (mailed, faxed, etc) on _____ (Date) by _____ (PCHS Staff Initials)

☐ **Payment info provided at time of service** ☐ **Payment received:** _____ (Date)

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, 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 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.

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 or fax number (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.