

I, \_\_\_\_\_, the undersigned, authorize the use and/or disclosure of my Protected Health Information ("PHI") as described below. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on the signing of this authorization.

- Psychotherapy Notes:** Check here if this authorization is for psychotherapy notes. If so, please disregard item 4 (below) as this authorization cannot be used for any other purpose if Psychotherapy Notes is checked.
- HIV-related Information:** Check here if this authorization is for HIV-related information. If so, in addition to completing this form, please complete the New York State Department of Health mandated Authorization for the Release of Confidential HIV-Related Information.

**1. Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number \_\_\_\_\_ SU ID Number \_\_\_\_\_

**2. Person(s) Authorized to Disclose PHI:**

- Syracuse University Human Resources Service Center
- Other: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**3. Person(s) Authorized to Receive PHI:**

- Syracuse University Human Resources Service Center
- Other: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**4. Description of PHI to be Disclosed:** (entire medical record; lab/x-ray reports; specific dates of service; etc.):

- Entire medical record
- Other (reports, dates of service, etc.): \_\_\_\_\_

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

**6. Expiration Date/Event:** This authorization will expire:

- Upon completion of the requested disclosure
- On \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)
- Six-months from date of this authorization form
- One-year from date of this authorization form

**This authorization shall become effective immediately. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that it has already been relied upon. I understand that in order to revoke this authorization my revocation must be submitted in writing to: \_\_\_\_\_ . I further understand that when my PHI is disclosed pursuant to this authorization it may be subject to redisclosure by the person(s) authorized to receive my PHI.**

Dated: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority