St. Joseph's University NEW YORK

Send Completed Release to:
Lindsay Monaco, MPH, CPH
Immunization Compliance Manager
319 W. Roe Blvd.
Patchogue, NY 11772
lmonaco2@sjcny.edu
FAX: 631.654.3602

Authorization to Release Protected Health Information (PHI)

Student Name: _____ SJNYID: _____

Phone Number: _____ Date of Birth: _____

Mailing Address: _____ Today's Date: _____

_____

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: [CHECK AS APPROPRIATE]

☐ **FROM** or □ **TO**
St. Joseph's University Brooklyn

☐ **FROM** or □ **TO**
St. Joseph's University Patchogue

□ **FROM** or □ **TO**
Name: _____
Title: _____
Department: _____
Street Address: _____
_____
City, State, Zip: _____
Phone Number: _____
FAX Number: _____

□ **FROM** or □ **TO**
Name: _____
Title: _____
Department: _____
Street Address: _____
_____
City, State, Zip: _____
Phone Number: _____
FAX Number: _____

DATES OF RECORDS/INFORMATION
FROM: ____/____/____ **TO:** ___/___/___

TYPES OF RECORD(S) INFORMATION [Check as appropriate]
□ Entire Medical Record
□ Immunization Record(s)
□ Mental Health Record(s) (except psychotherapy notes)
□ Other (please specify):

_____

If the information includes records or information from another health care provider or entity, that information:
[Check one] ____ **should** or ____ **should not** be released under this Authorization.

Please Note: This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address or fax number. Additional Information or disclosure to another person or entity or another address or fax will require another Authorization.

METHOD OF DISCLOSURE
Please release my records/information via: [Check as appropriate]
__ Mail __ Fax __in person pick-up by patient __Verbal

Please Note: Faxing may compromise your privacy.

PURPOSE OF AUTHORIZATION

The authorization is for the following purpose: [Check one and complete as needed]

__Personal Use __Patient Care __Legal __Parent/Guardian Communication __Insurance

Other:_____

EXPIRATION OF AUTHORIZATION

[Insert defined event or date not later than one year from the date Authorization is signed]

This Authorization will expire on: _____.

Student/Patient Acknowledgement-Please Read Carefully

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization.

In order for my revocation to be effective, it must be in writing. The revocation must include:

- The student's name, address and identification number, if applicable
- Sufficient information to identity this Authorization including date and recipient of PHI
- The student's desire to revoke this Authorization
- The intended date of the revocation, if later than the receipt of the revocation, and
- The student's signature

ALL revocations must be sent in writing to the entity releasing the PHI at the address provided above. A revocation is not effective until the later of the date it is received by the entity or any other date specified in the revocation.

The Office of Health Services will accept written revocations of this Authorization, via:

• Hand Delivery • Certified US Mail • Facsimile at 631.654.3602

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Conditioning Treatment, etc: I understand that the Office of Health Services will not condition my treatment, enrollment in a health plan or eligibility for benefits on whether I provide Authorization for a requested use or disclosure except in limited circumstances, such as certain research related treatment or health care solely for the purpose of providing information to another person or entity.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENTS OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

_____ _____

Student/Patient or Personal Representative Signature **Date**

_____ _____

Print Name of Patient/Personal Representative Relationship to Patient

The Office of Health Services reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information.

FOR INTERNAL OFFICE USE ONLY

Authorization verified and added to the student's medical record:

By_____ On: _____

Copy of Authorization given to student, if applicable:

By_____ On: _____

Disclosures made in response to Authorization (PHI), (date and recipient) are to be documented in the patient's medical record.

Revocation Received: _____

Statement and/or information mailed/faxed to parent/student/other:

By_____ On: _____