CornellHealth

Health Leave of Absence Release of Information Authorization

INSTRUCTIONS:

OPTIONS FOR COMPLETING FORM:

- Print this form and complete in ink; OR
- Download a copy of this PDF on your device
    - Rename the PDF and save
    - Complete form on your device
    - Save again

OPTIONS FOR SUBMITTING FORM:

- Print form, and
    - Give to your Cornell Health provider; OR
    - Mail it to: Cornell Health, Attention: HLOA, 110 Ho Plaza, Ithaca, NY 14583
    - FAX to: 607-255-0269
- OR upload through secure patient portal:
    - Go to mycornellhealth.health.cornell.edu
    - Log in with Cornell NetID, password, and date of birth
    - From Home screen select “Messages”
    - Then “New Message”
    - Then “Send message or attachment to [Health Records]”
    - Identify document in subject window and attach document

I authorize Cornell Health to disclose the minimum health information necessary to coordinate my health leave of absence. I allow Cornell Health to disclose information with (check one or more of the boxes below):

- ☐ Health Leave of Absence Coordinator
- ☐ My college Student Services office
- ☐ Office of Graduate Student Life
- ☐ Veterinary College Student Services
- ☐ Johnson School Student Services
- ☐ Other:_____

I understand that signing this form is voluntary. My treatment, payment or eligibility for services will not be conditioned upon my authorization of this disclosure.

Unless otherwise revoked, this authorization will expire one year from the date of the signature.

I may revoke this authorization in writing at any time, except to the extent that Cornell Health has already relied on this authorization. I make revoke it by sending a written notice to the Records

Administrator at 110 Ho Plaza, Ithaca, NY 14853 OR FAX to 607-255-0269, stating my intent to revoke this authorization.

I understand that information related to treatment for history or drug abuse or HIV or AIDS will only be disclosed if this is the primary reason for my health leave of absence.

I understand that information disclosed under this authorization might be redisclosed by the recipient and may no longer be protected by privacy laws.

I understand that a photocopy or facsimile copy of this authorization will be considered as effective and valid as the original.

I have read and full understand the above statements and consent to the disclosure of my health record for the purpose and extent stated above.

Signature Date

revised 9.25.20