Cornell University

Cornell Health

Authorization for Release of Health Records

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Last Name _____ First Name _____ Date of birth ____/____/____

Email Address _____ CU ID# _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

2. RELEASE RECORDS ☐ FROM or ☐ TO ⟷ RELEASE RECORDS ☐ FROM or ☐ TO

Cornell Health – Health Records Dept.
110 Ho Plaza
Ithaca, NY 14853-3101
Phone: 607-255-4082 Fax: 607-255-0269

Name/Organization _____
Street Address _____
City / State / Zip Code _____
Phone ____/____ Fax ____/____

☐ **Mail records** ☐ **Fax records** (we will not fax records over 10 pages)
☐ **Call for pick-up** ☐ **Discuss verbally** (no copying of records necessary)

► A fee may be associated with your request for release of records.

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL HEALTH RECORD

	DATE OF SERVICE / CONTENT		DATE OF SERVICE / CONTENT
☐ Office visit		☐ Radiology report	
☐ Gyn visits		☐ X-ray image disk	
☐ Lab work		☐ Billing receipts	
☐ Immunizations		☐ Entire record	
☐ Phys. Therapy notes		☐ Other	

► If specific date(s) or provider(s) are not indicated, all records in the category marked will be released.

4. INFORMATION TO BE RELEASED FROM YOUR RECORD RELATED TO COUNSELING AND PSYCHOLOGICAL SERVICES

	DATE OF SERVICE / CONTENT	► YOUR INITIALS ARE REQUIRED
☐ Office visit		►_____
☐ Medication history		►_____
☐ Lab work		►_____
☐ Entire record		►_____
☐ Summary of evaluation and treatment		►_____
☐ Minimum information needed to coordinate academic consideration / health leave of absence		►_____

5. SPECIAL INSTRUCTIONS _____

6. REASON FOR RELEASE OF INFORMATION _____

7. SIGNATURE OF PATIENT/CLIENT (or representative authorized by law)

- 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 on (date or event) _____.
  If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my 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 may revoke it by sending a written notice to the Records Administrator (at the address/fax# above) stating my intent to revoke this authorization.
- I understand that the records released may include information relating to HIV or AIDS, and I have read the reverse side of this form.
- I understand that the records released may include information relating to treatment for or history of drug or alcohol abuse.
- 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 shall be considered as effective and valid as the original.

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

► Signature _____ ► Today's date _____

CORNELL HEALTH USE ONLY

Date released: _____ Released by: _____

Notes: _____

Release of HIV-Related Information

- Please be aware that the records you have authorized for release may include information relating to discussion, testing, or treatment of HIV or AIDS.

  If you do not want such information to be included in this release, please write "exclude HIV-related information" in the "Special Instructions" area of this form.

Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV infection, HIV related illness or AIDS, or any information that could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV-related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals or other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law.

For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 800.962.5065.

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 800.523.2437 or 212.480.2493, or the New York City Commission of Human Rights at 212.306.5070. These agencies are responsible for protecting your rights.

Authorization form approved by State of New York Department of Health 10/00; revised 06/07, 09/08, 10/10, 02/11, 04/15