BINGHAMTON UNIVERSITY | DECKER STUDENT HEALTH SERVICES CENTER

Authorization for Release of Protected Health Information

Patient name: _____ DOB: _____ B-Number: _____

Birth name: _____ Phone/cell: _____

Home address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization includes all available disclosure of information relating to ALCOHOL and DRUG TREATENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any to these types of information, and I initial the line on the box in Item 8. I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name of Provider or Entity to Release this Information:

BINGHAMTON UNIVERSITY EATING DISORDERS TREATMENT TEAM

Decker Student Health Services Center	University Counseling Center	Nutrition services
PO Box 6000	PO Box 6000	PO Box 6000
Binghamton, NY 13902	Binghamton, NY13902	Binghamton, NY13902
Phone: 607-777-2221	Phone: 607-777-2772	Phone: 607-777-2883
Fax: 607-777-2881	Fax: 607-777-2708	Fax: 607-777-2296

6. Name, address, phone number and fax number of the providor or entity to whom this informatio will be disclosed:

CARE TEAM / CASE MANAGEMENT DEPARTMENT
PO Box 6000
Binghamton, NY 13902
Phone: 607-777-2804
Fax: 607-777-6486

7. Purpose for Release of Information: **COORDINATION OF CARE**

8. Unless previously revoked by me, the specific information below may be disclosed from: **date of first appt. through 1 year after last appt.**

Specific health information to release: **Records/information necessary for treatment coordination for disordered eating. Such records may specifically include clinical records from medical and mental health services.**

If not the patient, name of person signing form:	Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered, and I have been provided a copy of the form. Photocopies and/or scanned versions of this form that show my signature are as valid as a form with an original signature.

_____ _____
Signature of Patient or Representative Authorized by law Date

Witness Statement/Signature: I have witnessed the execution of this authorization andf state that a copy of the signed authorization was provided to the patient and/or the patient's authorized rpresentative.

_____ _____ _____
Name and title Signature Date

Created: 8-15-2022