Syracuse University
Human Resources

AUTHORIZATION
For the Use and Disclosure of Protected Health Information

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.

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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 Shared Services
   - ☐ Other: Name: _____

     Address: _____

     City: _____ State: _____ Zip: _____

3. **Person(s) Authorized to Receive PHI:**
   - ☐ Syracuse University Human Resources Shared Services
   - ☐ 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
   - ☐ Six-months from date of this authorization form
   - ☐ On _____/_____/_____ *(MM/DD/YYYY)*
   - ☐ 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