AUTHORIZATION FOR INFORMATION RELEASE
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 in benefits or eligibility for benefits will not be conditioned on the signing of this authorization.

□ **HIV-related Information:** Check here if this authorization is for HIV-related information. If so, in addition to completing this form, please complete a 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: _____

2. **Person(s) Authorized to Disclose PHI:**
   Name:
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____ Fax:
   _____

3. **Person(s) Authorized to Receive PHI:** (check applicable persons)

_____ Audrey Hoover, Director
University Health Care
1 Pace Plaza, 6th Floor
East New York, NY 10038

_____ Dr. Richard Shadick, Director
Counseling Center
156 William Street, 8th
Floor New York, NY 10038

_____ Karen Martin, Associate Director
University Health Care
Paton House, Ground
Floor 861 Bedford Avenue
Pleasantville, NY 10570

_____ Dr. Rosa Ament, Director
Counseling Center
Administration Center, 2nd
Floor 861 Bedford Road
Pleasantville, NY 10570

4. **Description of PHI to be Disclosed**:

_____ Diagnosis
_____ Diagnostic code
_____ Symptoms
_____ Other (describe directly below)

_____ Summary of treatment
_____ Treatment
recommendations _____ Current
clinical status

_____
_____
_____

_____
_____
_____
_____
_____

5. **Reason for Disclosure**: Please indicate the reason for the disclosure of the above stated PHI:

_____ Request for medical leave of absence from Pace University

_____ Request to resume studies at Pace University after a medical leave of absence

6. **Expiration Date/Event:** This authorization will expire upon the date a final decision is made with to respect to my resumption of studies at Pace University unless it is revoked earlier in a writing sent to Office of Student Assistance, Pace University, Payment Processing Center, Pleasantville, NY 10570.

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 the University Registrar, Office of Student Assistance. 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

This completed and signed form should be returned to:
Office of Student Assistance
Payment Processing Center
861 Bedford Road
Pleasantville, New York, NY 10570
osa_appeals@pace.edu