

**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, 6 th Floor East New York, NY 10038 | _____ Dr. Richard Shadick, Director Counseling Center 156 William Street, 8 th 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, 2 nd Floor 861 Bedford Road Pleasantville, NY 10570 |

4. Description of PHI to be Disclosed:

| | |
|---|-------------------------------|
| _____ Diagnosis | _____ Summary of treatment |
| _____ Diagnostic code | _____ Treatment |
| _____ Symptoms | recommendations _____ Current |
| _____ Other (describe directly below) 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 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