AUTHORIZATION FOR INFORMATION RELEASE
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, the undersigned, authorize the use and/or disclosure of P\ 3 U R W H F W H G + H D O W K , Q I R U P D W L R Q ³ 3 + , ´ D V n G, payment, Enrollment AUTHORIZ 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 the New York State Department of Health mandated Authorization for the Release of Confidential HIV-Related Information.

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

_____ Dr. Rosa Amen 1 365.95 315.89 Tm [(E BT 1 0

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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

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