PATIENTS: PLEASE ALSO INCLUDE COPY OF A PHOTO ID

NYU LANGONE HEALTH AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) - PATHOLOGY MATERIAL

Patient Name	Patient Date of Birth	Telephone Number
Patient 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. Information relating to **ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT, GENETIC TESTING,** and/or **CONFIDENTIAL HIV*-RELATED INFORMATION** will not be shared unless I specifically give permission. By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form.

____	Alcohol or Drug Treatment Information (records from alcohol/drug treatment programs)
____	Mental Health Treatment Information (except psychotherapy notes which require a separate form)
____	Genetic Testing Information
____	HIV/AIDS-Related Information (release of this information must include the required statements regarding the prohibition of redisclosure when required by law)

2. Except for the special types of information listed above, information that is shared because of this authorization may be shared again by the recipient and no longer protected by federal or state law. Unless permitted by federal or state law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I can revoke this authorization at any time by providing a written notice of revocation faxed to the Pathology Department at 212-263-7916. This revocation will be effective except to the extent NYU Langone Health has already relied upon this authorization.
4. Signing this authorization is voluntary. NYU Langone Health may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
5. I understand the pathology material I am requesting is original and cannot be replaced. I am releasing NYU Langone Health, including NYU Langone Hospitals, from all responsibility for the maintenance of this pathology material.

Description of information/material being released:

Date of Procedure: _____ Accession Number (if known): _____

✔ Pathology Slide(s) _____

☐ Implant/foreign body _____

✔ Pathology Report _____

(3/18)

NYU LANGONE HEALTH

Purpose for release of information:

Please explain: _____

Person receiving this information:

✔ Send to:

Name/Institution	Address Telephone Number: Fax Number (if applicable):

☐ I (or my personal representative) will pick it up and deliver to:

Name/Institution	Address Telephone Number: Fax Number (if applicable):

Authorization will end one (1) year from the date signed, unless stated here (specific event or date):

_____

My questions, if any, have been answered. In addition, I have been provided or offered a copy of this form if NYU Langone Health has asked me to complete this form.

Signature: _____ Date: _____ Time: _____AM/PM
(Patient or person authorized to sign)
If the person consenting is not the patient, print name and type of authority to sign.
Supporting documentation should be provided at the time of the request.

Name/Authority: _____

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protected information which reasonable could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Note: This form should be scanned into the patient's electronic medical record.

Office Use Only: MRN: _____ Received: ___/___/___ Initials: _____

(3/18)