Authorization to Disclose Health Information

NEW YORK INSTITUTE OF TECHNOLOGY

PART I: STUDENT INFORMATION

Last name		**First name**	
Date of birth		**NYIT ID**	
Address			
City		**State**	**Zip code**
Phone number		**Dates enrolled at NYIT**	

PART II: AUTHORIZATION

Do you authorize NYIT Office of Wellness Service to disclose your information to the person or organization indicated below? ◯ Yes ◯ No

Check all methods by which you will allow NYIT to disclose your information: ☐ Mail ☐ Fax

To whom do you wish to release your protected health information?

Name of Person/Organization			
Address			
City		**State**	**Zip code**
Phone number		**Fax number**	

Information to be disclosed (please check below to indicate information requested)

☐ Immunizations

☐ Other (please indicate)

I understand that:

– I may revoke this authorization at any time.

– The revocation will not apply to information that has already been released in response to this authorization.

– I must revoke this authorization in writing.

– I may refuse to sign this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

This authorization will expire automatically in ninety (90) days from the date of signature, unless otherwise revoked. Or, you may specify an expiration date, event, or condition earlier than 90 days.

I have read and understand the information in this authorization form.

Signature of student (Parent/guardian signature if student is under 18)

Printed name		**Date**	

Proof of identification with signature must be submitted with this form. Electronic signatures will not be accepted.

For Office Use		
Date completed	Number of pages copies	Initials

OFFICE OF WELLNESS SERVICES INFORMATION

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