

# BARNARD

THE LIBERAL ARTS COLLEGE  
FOR WOMEN  
IN NEW YORK CITY

For office use only

- [ ] Mailed (date) \_\_/\_\_/\_\_ (initial) \_\_\_\_\_  
[ ] Faxed (date) \_\_/\_\_/\_\_ (initial) \_\_\_\_\_  
[ ] Left at Front Desk for Pick-up (date) \_\_/\_\_/\_\_ (initial) \_\_\_\_\_

Primary Care Health Service  
Lower Level Brooks Hall  
3009 Broadway  
New York, NY 10027-6598  
Phone: 212-854-2091  
Fax: 212-854-2702

## Authorization to Release Medical Records

*This form provides the authorization necessary for the release of your protected health information. Please print legibly in black ink. Fax or mail this form, or bring it to our office. We cannot accept it via email for privacy and security reasons.*

Name: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_  
Last, First  
Cell phone: \_\_\_\_\_ Email \_\_\_\_\_ Graduation year \_\_\_\_\_

### Authorizes Release of Protected Health Information

From:

Barnard College Student Health Service

To: (Name, Fax **OR** Address)

\_\_\_\_\_  
\_\_\_\_\_

From (another provider)

\_\_\_\_\_  
\_\_\_\_\_

To: Barnard College Student Health Service

**OR**

Check here if you will return to pick-up records

### Specific Description of Information (choose one):

Check here for immunization records only  Records from \_\_/\_\_/\_\_ to \_\_/\_\_/\_\_ (dates)

Records that contain the following specified information:

\_\_\_\_\_

I hereby give consent for the release of any HIV-related information that may be in my medical record only to the designated person(s)/clinic(s) listed above

**Charges for medical records:** Current students no charge; Alumnae/previous students: \$0.75/per page  
Each additional U.S. fax # or address, add \$1.00; International fax # or international address add \$2.00

\_\_\_\_\_  
Visa or MasterCard (circle one)

\_\_\_\_/\_\_\_\_  
Exp. Date

\_\_\_\_\_  
CID (3 digits on back of card)

\_\_\_\_\_  
billing zip code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Director of the Barnard College Student Health Service, except to the extent that Barnard College has already taken action based upon my authorizations. Unless otherwise revoked, this authorization will expire 6 months from date of signature. A copy of this form is available to me upon my request. *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

\_\_\_\_\_  
Signature of Individual

Date: \_\_/\_\_/\_\_\_\_

\_\_\_\_\_  
Printed Name