



Health Services
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Syracuse, New York 13210
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Authorization for Use and Disclosure of Health Information

Name _____ Date of Birth _____

By signing this form, I hereby authorize _____ to disclose the health information described below to _____
(Name and Address of Person or Organization)

(Check All That Apply):

- All health information
 Health information relating to the following treatment or condition _____

 Health information for the date(s) _____
 Other specific description _____

Reason for This Authorization:

- At my request
 Other (specify) _____

This authorization expires on _____
(Date or Description of Event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested to the Privacy Officer and the health care provider listed above.

Once health information is disclosed to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

(Patient/Legally Authorized Representative)

(Date)

(Printed Name)

(Relationship to Patient)

Note: This document must be made a part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

This authorization must be signed by the patient.

I hereby authorize the SYRACUSE CITY SCHOOL DISTRICT to obtain information from:

Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):
Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):

I hereby authorize the SYRACUSE CITY SCHOOL DISTRICT to release information from:

Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):