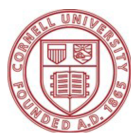

Cornell University

# Cornell Health

## Authorization for Release of Health Records

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Name ______________________________ Date of birth ______________

Email Address ______________ CU ID# ______________ Phone # ______________

Address ______________ City ______________ State ______ Zip Code ______

2. RELEASE RECORDS FROM and/or TO ↔ RELEASE RECORDS FROM and/or TO

Cornell Health – Health Records Dept.
110 Ho Plaza
Ithaca, NY 14853-3101
Phone: 607-255-4082 Fax: 607-255-0269

Name/Organization ______________________________
Street Address ______________________________
City / State / Zip Code ______________________________
Phone ______________ Fax ______________

**Mail records** (☐ paper or thumb drive) **Fax records** **Call for pick-up** **Place records on patient portal** **E-mail records** (by checking this box you understand that there is a risk that the requested information could be viewed by an unauthorized person when transmitted over the internet.)

**Secure File Transfer** (only use if information is being sent directly to you the patient, to your Cornell e-mail and you have an active NetID, or to someone else who is part of the Cornell community and has an active NetID).

**None of the above. Discuss verbally** (no copying of records necessary)

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL/PRIMARY HEALTH RECORD

Choose **one of the options** below to indicate what information should be shared from your General/Primary Care Record:

Share **all** of my general/primary care information (e.g., diagnoses, medications, test results, office notes, immunizations, surveys, questionnaires, patient histories, referrals, consults, and billing records)

Share **most of** my general/primary care information. **Do NOT share the following**:

______________________________________________________________

Only share the following types of general/primary care information:

______________________________________________________________

4. INFORMATION TO BE RELEASED FROM YOUR RECORD RELATED TO BEHAVIORAL HEALTH, COUNSELING AND PSYCHOLOGICAL SERVICES AND SUBSTANCE USE TREATMENT RECORD

Choose **one of the options** below to indicate what information should be shared from your Behavioral Health, CAPS, and Substance Use Treatment Record:

Share **all** of my behavioral health, CAPS and Substance Use Treatment information (e.g., diagnoses, medications, test results, Therapy Notes, assessments/evaluations, treatment plans, surveys, questionnaires, consults, client histories, and billing records)

Share **most of** my behavioral health, CAPS and Substance Use Treatment information. **Do NOT share the following**:

______________________________________________________________

Only share the following types of behavioral health, CAPS and Substance Use Treatment information:

______________________________________________________________

5. REASON FOR RELEASE:______________________________________________

6. SIGNATURE OF PATIENT/CLIENT (or representative authorized by law)

- I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.
- Unless otherwise revoked, this authorization will expire on (date or event) ______________.
  If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.
- I may revoke this authorization in writing at any time, except to the extent that Cornell Health has already relied on this authorization.
  I may revoke it by sending a written notice to the Records Administrator (at the address/fax# above) stating my intent to revoke this authorization.
- I understand that the records released may include information relating to HIV or AIDS and/or alcohol or drug treatment and I have read the reverse side of this form.
- I understand that information disclosed under this authorization might be redisclosed by the recipient and may no longer be protected by privacy laws.
- I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.

I have read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above.

▶ Signature of patient:______________________________ ▶ Date: ______________
(if signed by person other than the patient, state relationship and authority to do so)

INTERNAL USE ONLY: _______ SCAN ONLY Via: _____ Mail _____ Fax Other: ___________ Release date:___________ Completed by (initials)___________

## Release of HIV-Related Information

- Please be aware that the records you have authorized for release may include information relating to discussion, testing, or treatment of HIV or AIDS.

- If you do not want HIV-related information to be included in this release, please write “exclude HIV-related information” in the area designated under “Do NOT share the following” found in sections 3 and/or 4 on the front of this form.

  Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV infection, HIV related illness or AIDS, or any information that could indicate that a person has been potentially exposed to HIV.

  Under New York State Law, confidential HIV-related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals or other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

  State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law.

  For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 800-962-5065.

  The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 800-523-2437 or 212-480-2493, or the New York City Commission of Human Rights at 212-306-5070. These agencies are responsible for protecting your rights.

## Release of Substance Use Treatment Information

- Please be aware that the records you have authorized for release may include information relating to substance use treatment information.

- If you do not want substance use treatment information to be included in this release, please write “exclude substance use treatment related information” in the area designated under “Do NOT share the following” found in sections 3 and/or 4 on the front of this form.

  Records disclosed pursuant to this authorization related to substance use treatment, 42 CFR Part 2 prohibits the recipient from disclosing such records without your specific consent.

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## To submit forms to Cornell Health, please use one of these options:

- In person at Cornell Health (Level 6)
- By FAX: 607-255-0269
- By mail: Cornell Health, Attn: Health Records
  110 Ho Plaza Ithaca, NY 14853-3101
- Upload at myCornellHealth.health.cornell.edu:
  - From Home Screen, click on “Messages”
  - Then “New message;” then “Send message or attachment to Health Records”

revised 4/18/24