FIT Fashion Institute of Technology
Student Health Services
Seventh Avenue at 27 Street, New York City 10001-5992

Authorization to Disclose Health Information

PATIENT INFORMATION

Patient Name: _____ DOB: _____ ID# / SS#: _____

FACILITY / PERSON RELEASING INFORMATION

Name of facility / person: _____

Address: _____

Phone#: _____ Fax#: _____

FACILITY / PERSON TO WHOM INFORMATION WILL BE DISCLOSED

Name of facility / person: **FASHION INSTITUTE OF TECHNOLOGY HEALTH SERVICES**

Relationship: ❑ Healthcare Provider ❑ Self ❑ Parent ❑ FIT Professor ❑ Other: _____

If requesting copies of records sent, complete information on the right.

Street address: **SEVENTH AVE AT 27TH ST, ROOM A402**

City: **NEW YORK** State: **NY** Zip Code: **10001**

Phone#: **(212) 217-4190** Fax#: **(212) 217-4191**

INFORMATION TO BE RELEASED

- ❑ Information related to visit(s) on
  Date(s): _____
- ❑ Complete records including HIV/AIDS-related info
- ❑ Other: _____
- ❑ Gynecology
- ❑ Pap Smear results only
- ❑ Lab results including HIV/AIDS results

This authorization will expire in 6 months from the date this form is signed or the expiration date specified below, whichever occurs earlier.

Expiration date: _____

I, or my authorized representative, authorize the use or disclosure of my medical information as I have described on this form. All facilities/persons listed on this form may share information among and between themselves for the purpose of providing medical care and services.

Signature: _____ Date: _____
Patient or legally authorized representative

Print Name: _____ Phone#: _____

OFFICE USE ONLY:

Received / Approved: _____ Date: _____ Records sent on _____ Initial: _____