

**Office of International Student and Scholar Services
Binghamton University
State University of New York**

AUTHORIZATION for HEALTH CARE / HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and the Office of International Student and Scholar Services is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, the ISSS will not use your PHI to advocate on your behalf with respect to health care or health insurance matters UNLESS you sign this form permitting the ISSS to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing. If you have any questions regarding what is set forth on this document, please contact Ms. Jill Harrington, Binghamton University's campus privacy official at 607-777-3734 or the State University Privacy Officer at privacy@sunyadm.suny.edu.

Patient Name: _____ Soc. Sec. Or ID #: _____ - _____ - _____

Address: _____

DOB: _____ Telephone #: _____ E-Mail _____

I hereby authorize representatives of the ISSS to release information related to my medical care for the specified date(s) or type(s) of service to the specified insurer(s) and/or provider(s):

Date(s) and/or Type(s) of Service:

- Health care for or on the following date(s) only: _____
- All health care provided
- Health care for specified condition/treatment: _____

Providers:

- All health care providers (including physicians and hospitals)
- Health care from the following provider(s) only: _____
Please specify individual provider(s)

Insurers:

- The specified health care insurers and/or HMOs: _____
Please specify individual insurer(s) and/or HMO(s)

By providing this authorization, I give permission for representatives of SUNY to discuss the medical care that I received from the above named providers, during the time period listed, as well as the actual or requested payment for such care, with both the providers and insurers listed above. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications. If not earlier rescinded by me, this authorization shall expire **one year from today's date:** _____.
(specify expiration date)

Print Name of Patient (or Personal Representative¹)

Signature of Patient (or Personal Representative¹)

Date

¹ As defined in 45 CRF §164.502(g)

**Office of International Student and Scholar Services
Binghamton University
State University of New York**

AUTHORIZATION for RELEASE OF CONFIDENTIAL HIV-RELATED INFORMATION

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 which 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, persons involved with foster care or adoption, parents and guardians who consent to care of minors; jail, prison, probation and parole employees, emergency response workers and other workers in hospitals, other regulated settings or medical offices who are exposed to blood/bodily fluids in the course of their employment, and organizations that review the services you receive. The 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 necessary to pay for care and treatment. Anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5000 and a jail term of up to one year. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065.

If you sign this form, HIV-related information can be given to the people listed on this form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

The law protects you from HIV-related discrimination in housing, employment, health care or other services. For more information, call the New York State Division Of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 417-5043 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name and Address of facility/provider obtaining release: International Student and Scholar Services, Binghamton University, Box 6000, Binghamton, New York 13902-6000.

Name of Person whose HIV-related information will be released:

Name and Address of Person signing this form (if other than above): _____

Relationship to person whose HIV-related information will be released: _____

Name and Address of person who will be given HIV-related information: _____

Reason for release of HIV-related information: _____

Time during which release is authorized: From _____ **To** _____

My questions about this form have been answered. I know that I do not have to allow release of HIV-related information, and that I can change my mind at any time.

Print Name of Patient (or Personal Representative²)

Signature of Patient (or Personal Representative¹)

Date

² As defined in 45 CRF §164.502(g)

**Office of International Student and Scholar Services
Binghamton University
State University of New York**

AUTHORIZATION for Release of Confidential Alcohol or Other Drug Information

I hereby authorize the Special Programs Coordinator of the Office of International Student and Scholar Services at Binghamton University to release to: _____
information regarding services received for the purpose of: _____

(e.g. coordination of treatment, obtaining information, insurance).

Patient Name: _____ Soc. Sec. Or ID #: _____ - _____ - _____

Address: _____

DOB: _____ Telephone #: _____ E-Mail _____

Date: _____

Witness: _____

Date: _____

This consent form is valid until: _____ (six months maximum before a new release form is signed).