THE RESEARCH FOUNDATION
The State University of New York

AUTHORIZATION for HEALTH CARE/HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and The Research Foundation of State University of New York (RF) 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 RF 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 RF 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 the RF Personnel Officer at your location or the RF Privacy Officer at privacy@rfsuny.org.

Patient Name: _____ Social Security #: _____-____-_____

Address: _____

_____

DOB: _____ Telephone #: _____(day) _____(eve)

I herby authorize RF staff 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 RF staff 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 If not earlier rescinded by me, this authorization shall expire on _____.
(specify expiration date)

_____ _____

Print Name of Patient (or Personal Representative[1]) Signature of Patient (or Personal Representative[1])

_____

Date

[1] As defined in 45 CRF §164.502(g)