BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Health and Counseling Services
PO Box 6000
Binghamton, New York 13902-6000
607-777-2221, Fax: 607-777-2881

Authorization for Release of Protected Health Information for Disordered Eating

Patient Name: ______________________ DOB: __________ B-Number __________
Print Clearly

Legal Name: ______________________ Phone/Cell: ______________________

Home Address: ______________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. This request allows communication to and from the entities identified. In addition, I understand that:

1. This authorization may include disclosure of pertinent information relating to ALCOHOL and DRUG TREATENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the person or entity listed below in Item 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that my eligibility for services may be affected in some circumstances if I do not sign this consent.
5. Photocopies and/or scanned versions of this form that show my signature are as valid as a form with an original signature.

6. Name of Provider or Entity to Release this Information:

BINGHAMTON UNIVERSITY EATING DISORDERS TREATMENT TEAM

Decker Student Health Services Center	University Counseling Center	Sodexo Nutrition Services
PO Box 6000	PO Box 6000	PO Box 6000
Binghamton, NY 13902	Binghamton, NY 13902	Binghamton, NY 13902
Phone: 607-777-2221	Phone: 607-777-2772	Phone: 607-777-2883
Fax: 607-777-2881	Fax: 607-777-2708	Fax: 607-777-2296

7. Name, Address, Phone Number, and Fax Number of the Provider or Entity to Whom this Information Will Be Disclosed:

CARE TEAM/CASE MANAGEMENT DEPARTMENT
PO Box 6000
Binghamton, NY 13902
Phone: 607-777-2804
Fax: 607-777-6486

8. Purpose for Release of Information: **COORDINATION OF CARE**

9. Unless previously revoked by me, the specific information below may be disclosed from: **date of first appt. through 1 year after last appt.**

Specific Health Information to Release: **Records/information necessary for treatment coordination for disordered eating. Such records may specifically include pertinent clinical records from medical, psychiatry, counseling, HIV, and alcohol/drug treatment services.**

If not the patient, name of person signing form:	Authority to sign on behalf of patient:

______________________________ ______________
Signature of Patient or Representative Authorized by Law - (electronic signature accepted, if uploaded via health portal) Date

Created: 11-2022