NEW YORK INSTITUTE OF TECHNOLOGY
COLLEGE OF OSTEOPATHIC MEDICINE

ACADEMIC HEALTH CARE CENTER
Northern Blvd, Old Westbury, NY 11568
(516) 686-1300 Fax: (516) 686-7890

FAMILY HEALTH CARE CENTER
267 Carleton Ave, Central Islip, NY 11722
(631) 348-3254 Fax: (631) 348-3031

HIPAA AUTHORIZATION

PATIENT NAME (PRINT):_____DATE OF BIRTH:_____

PATIENT ADDRESS:_____

I have read and understand the Notice of Privacy Practices describing the uses and disclosures of my health information. I understand my rights described in the Notice of Privacy Practices.

I authorize the New York Institute of Technology and/or their staff to leave medical information pertaining to my care and/or my billing information by the following methods and will assume responsibility to notify them should this information change:

Home Telephone Number: _____ yes_____ no_____

Ans. Machine: _____ yes _____ no _____

Work Telephone Number: _____ yes _____ no _____

Voice Mail: _____ yes no

Cell Phone Number: _____ yes _____ no _____

Email Address: _____ yes_____ no_____

_____ _____

AUTHORIZATION TO DISCUSS HEALTH INFORMATION:

a) Include: (Indicate by initialing) ___**Alcohol/Drug Treatment**
_____**Mental Health Information**
_____**HIV-Related Information**

b) By initialing here _____I authorize **New York Institute of Technology**
Initials

to discuss my health information with the following individual(s) listed:

Name:_____ Name:_____

Relationship to Patient: _____ Relationship to Patient: _____

Telephone Number: _____ Telephone Number: _____

☐ NYIT Athletic Trainers ☐ LIU Athletic Trainers

Print Name of Person Signing this Form: _____

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____
Signature of Patient or Representative Authorized by Law Date