



Authorization for the Use & Disclosure of Protected Health Information (PHI) Instructions

1. Complete all sections on the form. Incomplete forms will not be accepted.
2. List the provider/entity(ies) from which you are requesting records and submit as noted in the chart below.
3. If Alcohol/Drug Treatment, Mta H45 (e)6 (a)6 lt(h)2 (T37 (r)5 (e)-4 (a)6 (tme64 (n)2 (t,)]TJ 0 Tc 0 Tw215.63 0 i(n)2 (f52 (o)2 (r)5 m(a)6 (i(o)2 (n)]TJ 0 Tc 0 Tw42.74 0 Td ()Tj[(i)-2 (s)-1 n t)-2 o(be)4 (i)-2 (ca)4 (l)-2 u(d

NYU LANGONE HEALTH

Purpose for release of information:

At my request Continuity of Care

Other (please explain, including if for a government benefit or program): _____

Person receiving this information:

Self Other (name; ID required for pick up): _____

Form/Format



quiva