



**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:**

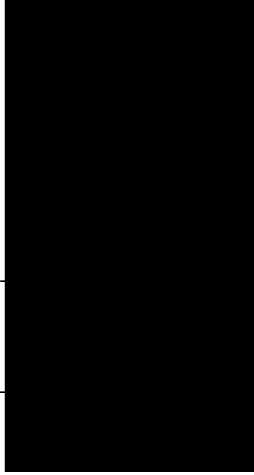
At my request                      Continuity of Care

Othe(r please explain, including if for a government benefit or program): \_\_\_\_\_

**Person receiving this information:**

Self    Othe(r name; ID required for pick up): \_\_\_\_\_

**Form/Format**



quiva