BROOKHAVEN
NATIONAL LABORATORY

Brookhaven Science Associates
Authorization for Use and Disclosure of Protected Health Information

I, _____, hereby voluntarily authorize the disclosure of Protected Health Information from my health records to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (Note: You may revoke this Authorization at any time by writing to the Brookhaven Science Associates, LLC Privacy Officer at the following address. Brookhaven Science Associates, LLC, Brookhaven National Laboratory, Attn: Privacy Officer, Benefits Office, Building 400B, Upton, NY 11973-5000.

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: This authorization is made at my request. I understand that treatment, payment, enrollment, or eligibility for Health Plan benefits is not affected by my decision to complete this Authorization form.

For internal use only: Date Received _____ *Approved by:* _____