Authorization for Release of Medical Information

Patient Name _____ ID#_____ Date of Birth_____

Phone #/Cell Phone #_____

I authorize and request _____
(Name of Clinician or Hospital RELEASING Information)

_____
(Address)

to release to/discuss with _____
(Name of Hospital or Individual TO RECEIVE Information)

_____
(Address)

Please check all that apply:

Effective dates for the period from _____ through _____

( ) Dean's Note
( ) Pre-Admission Health Form
( ) Immunization Records
( ) Laboratory Data
( ) Medical Leave of Absence
( ) Medical information concerning the history, treatment, examinations, laboratory studies and/or hospitalizations
( ) Psychological/Psychiatric assessment and/or treatment
( ) Medical information pertinent to treatment for alcohol or drug abuse
( ) Other_____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

NOTE: Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the" written consent of the person to whom it pertains or is otherwise permitted by 42 CFR, part 2.

_____ _____
Signature of Patient Date

_____
Witness

Student Health Service, SUNY Cortland
P.O. Box 2000, Cortland, NY 13045
Phone: (607) 753-4811 Fax: (607) 753-2486