SUNY Potsdam Watkins Student Health Center

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I AUTHORIZE:

_____

Person/organization currently holding my records

_____

Street Address

_____

City State Zip Code

_____ _____

Phone # Fax #

TO RELEASE MY RECORDS TO:

_____

Person/organization requesting my records

_____

Street Address

_____

City State Zip Code

_____ _____

Phone # Fax #

INFORMATION TO BE RELEASED (Check all that apply):

- □ Specify exactly what to release: _____
- □ All records pertaining to: _____
  _____
- □ Requestor and sender may discuss my medical care regarding: _____
- □ Immunization records

NOTE: Federal confidentiality rules (42 CFR part 2) protect records pertaining to alcohol, drug, or mental health information. These federal rules prohibit the Receiving facility from making further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

In addition, New York State does not allow the release of HIV related medical records without your expressly written permission. Unless you request it in the Special Authorization section below, your HIV related information will be redacted from the sent records.

SPECIAL AUTHORIZATION *(Check all applicable boxes and sign):*

By signing this section I authorize the SUNY Potsdam Student Health Services to release/obtain my medical records regarding:

□ Alcohol and drug treatment □ Mental health treatment □ HIV/AIDS treatment

Patient Signature: _____ Date: _____

PURPOSE OF DISCLOSURE:

- □ Continuation of medical care. □ Personal □ Legal
- □ Other: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

I authorize the transfer of the medical records indicated above. I understand that this authorization is valid until _____ or for one year unless otherwise specified. I understand I may revoke this consent at any time unless my records have already been sent. The records will be sent with a copy of this authorization.

_____ _____

Patient Signature Date

_____ _____

Patient's Name (printed) Patient's Former Last Name (if applicable)

Spring/Fall _____ _____ _____ _____

Last Semester/Year Attended DOB Student ID # Phone #

Office use only:

□ Please send indicated records. Signature: _____

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