SUNY Potsdam Watkins Student Health Center
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I AUTHORIZE:	**TO RELEASE MY RECORDS TO:**
________________________________ Person/organization currently holding my records	________________________________ Person/organization requesting my records
________________________________ Street Address	________________________________ Street Address
________________________________ City State Zip Code	________________________________ City State Zip Code
______________ Phone # ______________ Fax #	______________ Phone # ______________ Fax #

INFORMATION TO BE RELEASED (Check all that apply):

- □ Immunization records □ Pap smear report □ Most recent history and physical
- □ Lab/ X-ray report(s) regarding: ____.
- □ Records from time period _______ through ________ pertaining to ________________________________.
- □ Requestor and sender may discuss my medical care regarding: ______________________________________.
- □ Other:

PURPOSE OF DISCLOSURE:

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

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 requestor may be provided with a copy of this authorization.

____ ________________________________
Patient/Guardian Signature Date

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

Spring/Fall ____________________________ ________________ ________________________________
Last Semester/Year Attended DOB P#

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

By signing below 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 □ Sexually transmitted infections

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.

Patient/Guardian Signature: ____ Date: __________________

Office use only:
□ Please send indicated records. Signature: ____

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