AUTHORIZATION FOR RELEASE OF INFORMATION

THE STATE UNIVERSITY OF NEW YORK
Potsdam

Patient's Name (Last, First, M.I,) "C" No.

……..……

Sex…… Date of Birth……

Facility Name……..…..…Unit/Ward/Residence No…….

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Part 1: Authorization to Release Information

Description of Information to be Used/Disclosed

Purpose or Need for Information:

1. This information is being requested:
   - ☐ By the individual or his/her personal representatives; or
   - ☐ Other (please describe) _____
2. The purpose of the disclosure is (please describe):

From: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information	**To:** Name, Address, & Title of Person/Organization/Facility/Program to Which this Discloser is to be Made. *NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
_____ _____ _____ _____	**College Counseling Center** **44 Pierrepont Ave, 131 Van Housen Hall** **Potsdam, NY 13676** **# 315-267-2330** **Fax: 315-267-2228**

A. I hereby permit the use of disclosure of the above information to the Person/Organization/Facility/Program(s) Identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by SUNY Potsdam.
5. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR 164.524).

B-1 One-time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the Person/Organization/Program identified above.

My authorization will expire:

- ☐ When acted upon;
- ☐ 90 Days from this Date;

Other _____

Facility/Agency Name	Patient's Name (Last, First, MI)	"C"/Id. No

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:

- ☐ When I am no longer receiving services from SUNY Potsdam
- ☐ One year from this date;
- ☐ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff Person's Name and Title

Authorization Provided to: _____

Date: _____

To be completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

_____
Title

_____
Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient