

AUTHORIZATION TO RELEASE INFORMATION

Student Name: _____ Date of Birth: _____

Geneseo ID Number: _____

AUTHORIZATION FOR INFORMATION TO BE RELEASED BY:

Lauderdale Center for Student Health and Counseling

(Name of individual or organization)

INFORMATION TO BE RELEASED TO:

Lauderdale Center for Student Health and Counseling; Attn: _____

(Name of individual or organization)

Address: _____ Telephone _____
_____ Fax: _____

AUTHORIZE MUTUAL EXCHANGE OF INFORMATION

INFORMATION TO BE RELEASED:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Complete medical/treatment record | <input type="checkbox"/> Immunization record | <input type="checkbox"/> Physical exam/history | <input type="checkbox"/> Psychotherapy/treatment summary |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Laboratory test reports | <input type="checkbox"/> Visit verification |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> Other Information or Instructions (please specify):
_____ | | |

Records pertaining to HIV tests/counseling require separate authorization for release.

PERIOD(S) OF CARE:

From (date): _____ To (date): _____

Unless otherwise revoked this authorization will expire nine (9) months from the date of this request or on the following date: _____

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as contained in this authorization. I understand that this release pertains only to treatment provided by the authorized party(ies), and does not include release of information received from other treatment providers. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization.

Signature: _____

Date: _____

Witness: _____

This information has been disclosed from confidential records. State law prohibits any further disclosure of this information without the specific, written consent of the person to whom it pertains or as otherwise permitted by law.