SUNY Geneseo, 1 College Circle, Geneseo, NY 14454
Fax: 585-245-5744 Phone: 585-245-5736

Request for Immunization or Medical Records

I, (print name)___________________________________authorize SUNY Geneseo Health and Counseling to disclose the following information from my protected health records:

Requesting

☐ **Immunization Record (no charge)** ☐ **Complete medical/treatment Record ($8.00 charge)**

Period(s) of care to be released From: Until:

Required Information

Dates last attended From: Until:
Former Name (if applicable)
Geneseo ID number (G00)
Date of Birth
Phone Number Email

Information to be Released to:

☐ **Mail my records to the following location**
Name/Organization
Address
City State Zipcode
☐ **Fax my records to the following location**
Name/Organization
Fax Number

Payment Options

Card Type ☐ **VISA** ☐ **Mastercard** ☐ **Discover**
Name on Card
Card Number
Expiration Date Month: Year:

☐ **A check made out to SUNY Geneseo for the amount of $8.00 is enclosed**

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 re-disclosure. 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:___________________________________