



AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: _____ Date of Birth: _____ Geneseo ID Number: _____
 Student Phone #: _____ Email: _____

<p>I authorize Student Health and Counseling to RELEASE information TO:</p> <p>_____</p> <p>Name of individual(s) or organization</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip code</p> <p>_____</p> <p>Phone and Fax # (include area code)</p>	<p>I authorize Student Health and Counseling to OBTAIN information FROM:</p> <p>_____</p> <p>Name of individual(s) or organization</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip code</p> <p>_____</p> <p>Phone and Fax # (include area code)</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Mutual exchange of information

This request applies to Medical Records Counseling Records

From date _____ To date _____ (cannot be longer than one (1) academic year)

- | | | |
|----------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <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): _____ | |

I do not want to share AOD STI Other: _____

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

Authorization:

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 (s), 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. Signed releases of information, authorized by the patient, are time-limited, with written specified dates, and are diagnosis-related.

I understand that any disclosure of information carries with it the potential for 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.

Student Signature: _____ Date: _____

Witness: _____ Date: _____

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.

Accredited as a Medical Home by



Lauderdale Health Center
Ph: 585.245.5736
Fx: 585.245.5744

Counseling Services
Ph: 585.245.5716
Fx: 585.245.5071

Alcohol & Other Drug Services
Ph: 585.245.5716
Fx: 585.245.5071

Health Promotion
Ph: 585.245.5747
Fx: 585.245.5744

South Village Health Center
Ph: 585.245.5752
Fx: 585.245.5758