GENESEO

STATE UNIVERSITY OF NEW YORK AT GENESEO
Department of Student Health and Counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: ____________________________ Date of Birth:____________ Geneseo ID Number: ____________

Student Phone #: ______________________ Email:______________________________

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

This request applies to:

From (date) _______________ to (date) ________________.

- ☐ Immunization record
- ☐ Physical exam/history
- ☐ Psychotherapy/treatment summary
- ☐ Consultation reports
- ☐ X-ray reports
- ☐ Laboratory test reports
- ☐ Visit verification
- ☐ Treatment Recommendations
- ☐ Other Information or Instructions (please specify): ________________________

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. Health Services releases cannot be for broad, unlimited periods of time, such as a semester or academic year. Counseling Services releases can be written for up to one academic year. Exceptions may be made in cases of patient or legal requests for complete medical records.

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.

Signature:____ 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.