



GENESEO

NEW YORK'S PUBLIC HONORS COLLEGE

THE STATE UNIVERSITY OF NEW YORK

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: _____ Name of individual(s) or organization _____ Address _____ City, State, Zip code _____ Phone and Fax # (include area code)	I authorize Student Health and Counseling to OBTAIN information FROM: _____ Name of individual(s) or organization _____ Address _____ City, State, Zip code _____ Phone and Fax # (include area code)
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☐ Mutual exchange of information

This request applies to ☐ Medical Records ☐ Counseling Records

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

- | | | |
|--|--|--|
| ☐ Immunization record | ☐ Physical exam/history | ☐ Psychotherapy/treatment summary |
| ☐ Consultation reports | ☐ X-ray reports | ☐ Laboratory test reports |
| ☐ Treatment Recommendations | ☐ Visit verification | |
| ☐ Case Management | ☐ 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.

For Office Use only	
Request Received: _____	Documents Reviewed: _____
Medical Reviewed: _____	Date _____
Counseling Review: _____	Date _____