GENESEO
1871
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:**	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)

☐ 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 ☐ Visit verification
☐ Treatment Recommendations ☐ Other Information or Instructions (please specify): _____
☐ Case Management

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 _____