SUNY Orange Wellness Center

Shepard Student Center 115 South St., Middletown, NY 10940
Phone: (845) 341-4870 FAX: (845) 341-4872

Authorization to Release/Obtain Medical Records

Complete entire form to RELEASE or OBTAIN medical records. Please include a copy of your identification with request. Please allow 3 business days for the Wellness Center to process your request.

I hereby authorize the disclosure of information from my health records:

Student's First Name	Student's Last Name	Former or Maiden Name

Phone # (with area code)	A#	Date of Birth	Year Entered SUNY Orange	Year Left SUNY Orange

Health Information to disclose:

[ ] Immunization records [ ] Treatment Summary
[ ] All Information [ ] Other (specify) _____

Method of disclosure:

[ ] Release my medical records from SUNY Orange Wellness Center to:

Name: _____
Address: _____
FAX #:_____

[ ] Obtain my records from

Name: _____
Address: _____
FAX #: _____
Forward To: SUNY Orange Wellness Center
115 South Street Middletown, NY 10940
FAX: (845) 341-4872
Email- wellnesscenter@sunyorange.edu

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____ _____
Signature of Student (Parent/Guardian if student is under 18). Date

_____
Relationship to student (Parent/Guardian/Executor)

OFFICIAL USE ONLY
Date Received: _____ Date completed: _____ Data logged in: _____ Completed by_____

ID Presented: _____ Copy of ID Included: _____ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON