

[ ] **MIDDLETOWN CAMPUS**

Geo. F. Shepard Student Center

115 South St., Middletown, NY 10940

Phone: (845) 341-4870

FAX: (845) 341-4872

[ ] **NEWBURGH CAMPUS**

One Washington Center

Newburgh, NY 12550

Phone: (845) 341-4870

FAX: (845) 341-4872

**WELLNESS CENTER**

**Authorization to Release/Obtain Medical Records**

**Instructions:**

1. **Complete this entire form** to release/obtain medical records
2. Please ***allow 3 days*** for the Wellness Center to process your request.

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

|  |  |  |
| --- | --- | --- |
|  |  |  |

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 medical records **FROM** SUNY Orange Wellness Center to:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] release medical records **TO**

**SUNY Orange Wellness Center**, 115 South Street, Middletown, NY 10940 FAX: 845.341-4872

from: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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** ***File with record when completed***

Completed by\_\_\_\_\_\_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Presented:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON