Student ID:
____

Authorization to Release/Obtain Medical Records

Middletown Campus *115 South Street, Middletown, NY 10940*
Newburgh Campus *1 Washington Center, Newburgh, NY 12550*
(845) 341-4870 ● immunizations@sunyorange.edu

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. **Note:** we are unable to email your medical records.

Part 1: Student Information:

Last Name	First Name	Former or Maiden Name
Date of Birth	**A #**	**Phone Number**
______/______/______ mm dd yyyy	A___ ___ ___ ___ ___ ___ ___ ___	(________)______________

Part 2: Health Information To Disclose

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

Part 3: Method Of Disclosure

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

Name: ____
Address: ____
FAX #:____

[ ] **OBTAIN** my medical records from:

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

Part 3: Signature:

____ ______/______/______
Student/ Parent Signature if student is under 18 years mm dd yyyy

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:

Office Use Only

Date Rec'd: _________________ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON

ID Presented: ____________ Completed by:________ Date Completed:________________________