SUNY ORANGE
WELLNESS CENTER
Mind ~ Body ~ Spirit

OFFICIAL USE ONLY

Date Received:_____

WELLNESS CENTER

SUNY Orange County Community College
Geo. F. Shepard Student Center, 115 South Street, Middletown, NY 10940
Phone: (845) 341-4870 Fax: (845) 341-4872

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

Method of disclosure:

[ ] release medical records **FROM** SUNY Orange Wellness Center to:

Name:_____
Address:_____
Or FAX No.:_____

[ ] release medical records **TO** SUNY Orange Wellness Center from:

Name:_____
Address:_____
Or FAX No.:_____

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