Alfred University Wellness Center
Health Services
607-871-2400

19 Park Street
Alfred, New York 14843

Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may not longer be protected by federal privacy or other policy regulations

I authorize_____to disclose/obtain the following information from the medical records of:
PROVIDER HOLDING MEDICAL RECORD

Patient Name: Other Names: Date of Birth:
PRINT NAMES

Address:

Email: Telephone: Student ID Number:

The time of care beginning _____and ending_____
DATE DATE

Check one of the following: ____Current AU Student ____Not a Current AU Student (last year attended AU _____)

Information to be disclosed (INITIAL any of the following that apply):

___Immunization Records ___Laboratory Reports ___X-Ray Reports ____Class Attendance

___History and Physical Exam ___Medical Progress Notes ___Pap Smears

___Complete health records(s), Excluding all images.

I understand that information requested above will not include information relating to the following, unless INITIALED:

___AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection (additional HIV authorization required)

___Mental Health Care or services_____Treatment for alcohol and/or drug abuse___Photographs, videotapes, digital or other images

Purpose of disclosure: _____Medical ____Legal ___Insurance ___Other:_____

Release to:

Name: Phone:

Address:

I understand that unless earlier revoked, this authorization will expire within 60 days. I understand that I may revoke this authorization at any time by notifying my AU Health Services health care provider, or the Director of the AU Wellness Center. If I revoke authorization, I understand it will not have any effect on any action Health Services took before it received the revocation. I understand this authorization is voluntary. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or be eligible for benefits. Alfred University, The Wellness Center, Health Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

_____ _____ _____
Signature of Patient or Representative Relationship of Representative to Patient Date

_____ _____
Signature of Witness Date