FREDONIA
STATE UNIVERSITY OF NEW YORK

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student Name: _____Date of Birth:_____

Fredonia ID Number: _____

AUTHORIZATION FOR INFORMATION TO BE RELEASED BY FREDONIA STUDENT HEALTH CENTER TO THE BELOW STATED ORGANIZATION:

☐ _____
(Name of individual or organization)
Address:_____Telephone:_____
_____Fax:_____

AUTHORIZATION FOR INFORMATION TO BE RELEASED TO FREDONIA STUDENT HEALTH CENTER (FAX Number: 716-673-4722) FROM THE BELOW STATED ORGANIZATION:

☐ _____
(Name of individual or organization)
Address:_____Telephone:_____
_____Fax:_____

INFORMATION TO BE RELEASED: (Please print below what specific information you would like released)

☐ _____

I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I understand that this authorization may be revoked by me at any time in writing, and that it will automatically expire after 90 days from the date of my signature unless otherwise specified.

Signed: _____ Today's Date:_____

PROHIBITION ON REDISCLOSURE: I understand the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or disclosure is specifically required or permitted by law.

FOR OFFICE USE ONLY:

Health Center Personnel Releasing the Information: _____Date: _____