

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize the Ithaca College Student
[PRINT name & Ithaca College ID number]
Health Service to furnish any or all information (as listed below) contained in my medical records to:

[PRINT Health Care Provider's name & FAX number ~OR~ Name of person to receive records/information]

I understand that in executing this authorization I waive the right for such information to be privileged and realize that said information may not be kept strictly confidential by the recipient.

I do not authorize the release of HIV information if it is included in my record. A separate release form is required if HIV information is to be sent to another facility (see GEN-65).

This release is for information pertaining to the following illness(es) or diagnoses: _____

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying the Ithaca College Student Health Services in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by the Ithaca College Student Health Services before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires at the earlier of (date) _____ ~OR~ the date the following event occurs: _____

[describe event or write "not applicable"]

The last date that I attended Ithaca College is: _____

X Signed _____
(Parent/guardian if under 18)

X Witness _____

X Date _____

X Date _____

X Phone number: _____ (where you can be reached if there are any questions)

OFFICE USE ONLY

Records were: Faxed Mailed Picked up: Signature of person receiving records: _____

Health Center staff initials: _____ Date: _____