ITHACA COLLEGE
Hammond Health Center

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Student Name: (please print) _____ Date of Birth _____/_____/_____

Student ID: _____ Phone number: _____

2. RELEASE RECORDS ☐ FROM or ☐ TO ⟷ **RELEASE RECORDS ☐ FROM or ☐ TO**

Hammond Health Center - Ithaca College
953 Danby Rd., Ithaca, New York 14850
Phone: (607) 274-3177 Fax: (607) 274-1844
healthcenter@ithaca.edu

☐ Mail records ☐ Release to student in-person
☐ Fax records ☐ Discuss verbally

Name/Organization_____
_____
Street Address_____
City/State/Zip_____
Phone_____ Fax _____

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

_____

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.

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL MEDICAL RECORD:

	DATE OF SERVICE / CONTENT		DATE OF SERVICE / CONTENT
☐ Visit Notes	_____	☐ X-Ray Images	_____
☐ Immunizations	_____	☐ Radiology Reports	_____
☐ Lab Results	_____	☐ Prescription History	_____
☐ Sports Medicine Notes	_____	☐ Other (please specify)	_____

▶ If specific date(s) or provider (s) are not indicated, all records in the category marked will be released

4. SPECIAL INSTRUCTIONS

I acknowledge that the information to be released MAY INCLUDE information protected by federal and state laws. By initialing below, I DO AUTHORIZE the disclosure of the following information if it is included in my record:

_____ HIV Related Information _____ Psychotherapy/Psychiatric Records
_____ Alcohol/Drug Treatment _____ Sexual Assault Records

5. REASON FOR RELEASE OF INFORMATION

_____

- 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.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

Last date that I attended Ithaca College was _____

▶ Signature _____ Today's Date _____/_____/_____

▶ Witness _____ Today's Date _____/_____/_____

OFFICE USE ONLY
Records were ☐ Faxed ☐ Mailed ☐ Picked Up: Signature of person picking up._____
Health Center Staff initials _____ Date _____ revised 10/2016