SUNY Orange Wellness Center

 Shepard Student Center 115 South St., Middletown, NY 10940

Phone: (845) 341-4870 FAX: (845) 341-4872

**Authorization to Release/Obtain Medical Records**

Complete entire form to RELEASE or OBTAIN medical records. Please include a copy of your identification with request. Please allow 3 business days for the Wellness Center to process your request.

**I hereby authorize the disclosure of information from my health records:**

|  |  |  |
| --- | --- | --- |
|  |  |  |

 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 [ ] Treatment Summary

 [ ] All Information [ ] Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of disclosure:**

[ ] Release a copy of my immunizations to me.

[ ] Release my medical records from SUNY Orange Wellness Center to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Obtain my records from

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forward To: SUNY Orange Wellness Center

 115 South Street Middletown, NY 10940

 FAX: (845) 341-4872

 Email- wellnesscenter@sunyorange.edu

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**

 Date Received: \_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_ Data logged in: \_\_\_\_\_\_\_\_ Completed by\_\_\_\_\_\_\_\_\_\_\_\_

 ID Presented: \_\_\_\_\_\_\_\_ Copy of ID Included: \_\_\_\_\_\_\_\_ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON

Revised Release Form 04/2016.