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. **Note:** we are unable to email your medical records.

|  |
| --- |
| **Part 1: Student Information:**  |
| Last Name  | First Name  | Former or Maiden Name  |
|  |  |  |
| Date of Birth | A # | Phone Number |
| \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ mm dd yyyy | A\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_  | ) (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Part 2:** **Health Information To Disclose** |
|   [ ] Immunization records [ ] Treatment Summary [ ] All Information [ ] Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Part 3:** **Method Of Disclosure** |
| [ ] **RELEASE** my medical records from SUNY Orange Wellness Center to:Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] **OBTAIN** my medical records from:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forward To: SUNY Orange Wellness Center 115 South Street Middletown, NY 10940  FAX: (845) 341-4872  Email- immunizations@sunyorange.edu |
| **Part 3: Signature:**  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Student/ Parent Signature if student is under 18 years mm dd yyyy |
| 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: |
| Office Use Only  |
|   Date Rec’d: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON   ID Presented: \_\_\_\_\_\_\_\_\_\_\_\_ Completed by:\_\_\_\_\_\_\_\_ Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |