Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ (845) 257-3400 ▪ (845) 257-3415 (fax)

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS
FROM STUDENT HEALTH SERVICE TO HEALTH CARE PROVIDER/CARE FACILITY

Patient Name ____Date of Birth ______________ Phone # ___________________

Address ____

City ____ State _________________ Zip ___________________

I hereby authorize Student Health Service to release my protected health records to:

____
Provider/Health Care Facility

____
Address

____
City, State, Zip

____
Phone Fax

PLEASE CHOOSE ONE AND INITIAL:

☐ ______ **ENTIRE** Medical Record ☐ ______ **PARTIAL** Medical Record
Initial *Initial*

Specific information such as date(s) of service, level of detail to be released, specific doctor, etc.

____

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This authorization may include disclosure of information relating to **ALCOHOL AND DRUG TREATMENT, MENTAL HEALTH TREATMENT AND CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** only if I check the box and initial the appropriate line below.

☐ To release of mental health information Initial_________

☐ To release drug and alcohol abuse treatment information Initial_________

☐ To release HIV, AIDS-related information Initial_________

The information is being requested for the following purposes (check below):

☐ Appointment with health care provider, medical facility, etc.

☐ Other (please specify): ____

This Authorization will expire on ______________________ or one year form the date on this form.

Signing this authorization is voluntary.

When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and state privacy rules. The exception to re-disclosure is information related to **MENTAL HEALTH, DRUG AND ALCOHOL ABUSE TREATMENT AND HIV/AIDS-RELATED INFORMATION.** Further authorization will be required for re-disclosure by the recipient of this information.

I understand that this authorization is subject to revocation at any time, except to the extent action has been taken with reliance on it. In order to revoke this authorization I must deliver a revocation, in writing, to Student Health Service and after such revocation is delivered no further information will be furnished pursuant to this authorization.

______________________________ ______________________________ ______________________ ____________
Signature of Patient or Legal Guardian Print name of Patient or Legal Guardian Relationship to Patient Date

The patient or legal guardian must complete all items before the form can be processed.

7/2016