



Student Health Service ■ Division of Student Affairs

1Hawk Drive ■ New Paltz, NY ■ 12561-2443 ■ (845) 257-3400 ■ (845) 257-3415 (fax)

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

FROM STUDENT HEALTH SERVICE:

I hereby request SUNY New Paltz Student Health Service and its medical staff and employees to release the following identified information contained in the Student Health Service's medical records, to primary physician/health care facility:

Physician/Health Care Facility

Address

City, State, Zip

INITIALS

_____ Entire Medical record (INCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

_____ Partial Medical record (INCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

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

_____ Entire Medical record (EXCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

_____ Partial Medical record (EXCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

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

TO STUDENT HEALTH SERVICE:

I hereby request that my medical records be provided by:

Physician/Health Care Facility

Address

City, State, Zip

To: Student Health Service
State University of New York at New Paltz
1 Hawk Drive, New Paltz, NY 12561-2443
Fax: 845-257-3415

INITIALS

_____ Entire Medical record (INCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

_____ Partial Medical record (INCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

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

_____ Entire Medical record (EXCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

_____ Partial Medical record (EXCLUDING mental health information, drug and alcohol abuse treatment information, and communicable disease information, including human immunodeficiency virus (HIV), AIDS-related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record)

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

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

Initials _____

The information is being requested for the following purposes:

- Personal use. (There will be a fee based on the number of pages, so specify above if only a section is desired).
- Appointment with Health Care provider, medical facility, etc. (No charge if sent directly to office/facility).
- Other. (There will be a fee based on the number of pages, so specify if only a section is desired).

This Authorization will expire on _____

Expiration Date of Defined Event

I understand that SUNY New Paltz Student Health Service may not require me to sign this Authorization as a condition to providing health care treatment to me. 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.

Signature of Patient or Legal Guardian

Address

Phone Number

Print Name of Patient or Legal Guardian

Relationship to Patient

Date

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

*Parent, legal guardian, next of kin or legally appointed individual who represents the patient when the patient is: 1. Incompetent by judicial finding 2. Physically incapable 3. Mentally lacking capacity 4. A minor less than 18 years of age UNLESS: Patient is pregnant, patient is a parent, patient has been legally married