



New Paltz

STATE UNIVERSITY OF NEW YORK

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 TO STUDENT HEALTH SERVICE:

Patient's Name _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

I hereby request that my medical records be provided by:

Physician/Health Care Facility _____

Address _____

City, State, Zip _____

PLEASE CHOSE ONE AND INITIAL:

Entire Medical Record Partial Medical Record

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

Send to: MD/FNP/PA/RN _____

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State University of New York at New Paltz ■ 1 Hawk Drive, New Paltz, NY 12561-2443

Fax: 845-257-3415

PLEASE READ AND INITIAL BOTH, CIRCLE CHOICE (WHERE INDICATED):

I AGREE I DO NOT AGREE (circle one and initial)

to the release of 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)

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.

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

- Appointment with health care provider, medical facility, etc.
Administrative medical review (teaching clearance, sports clearance, medical-academic issues)
Other. (please specify)

This Authorization will expire on _____ or at the end of this academic year.

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