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 Name _____Date of Birth _____ Phone # _____

Address _____

City _____ State _____ Zip _____

I hereby request that my medical records be provided by:

_____
Physician/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.

_____

_____

TO: MD/ANP/RN _____**And SENT TO ADDRESS AT TOP OF PAGE**

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.

☐ Administrative medical review (teaching clearance, sports clearance, medical-academic issues)

☐ Other (please specify): _____

This Authorization will expire on _____ or one year from 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 re-disclosure 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 the health care provider/facility listed above 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.