Colgate University Student Health
13 Oak Drive
Hamilton, NY 13346-1398
Telephone: (315) 228-7750 Fax: (315) 228-6823

# Authorization for Release of Medical Information

Print Full Name _____ Class Year _____

Home Address _____ Date of Birth _____

_____ School Address _____

_____ _____

Home Phone _____ Cell Phone _____

**I hereby authorize the Colgate Student Health Center to:** ☐ release ☐ obtain ☐ discuss

**Medical information (which may include reports, X-rays):** ☐ to
☐ from

Care Provider/Other_____

Address _____

City/State/Zip _____

Phone # _____ Fax # _____

The following information_____

_____

Under State and / or Federal guidelines, certain diagnoses and treatment may not be released without specific authorization.
**Initial below if you want that specific information released.**

☐ I authorize release of information concerning drug and / or alcohol abuse and treatment.
☐ I authorize release of information concerning psychiatric treatment.
☐ I authorize release of information concerning HIV testing or treatment.

Reason for Authorization:

☐ Continuity of care ☐ Academic concerns / accommodations ☐ Hospitalization
☐ Insurance issue ☐ Other _____

I have read and understand this authorization. I expressly and voluntarily consent to disclose the above information to the persons / agencies named above. I release Colgate University from all legal responsibility that may arise from the release of these medical records. A photocopy of the consent shall be as valid as the original. This authorization will remain in effect for one year unless specifically revoked in writing.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

This information has been disclosed to you from records whose confidentially is protected by Federal Law. Federal regulation (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such, regulations.