COLGATE UNIVERSITY

Student Health Services
140 Broad Street
Hamilton, NY 13346
Telephone: (315) 228-7750 Fax: (315) 228-6823

Authorization for Release of Medical Information

Print Full Name: Date of Birth:
Home Address: School Address:

Home Phone: Cell Phone:

Student ID: Class Year:

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:

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

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 confidentiality is protected by Federal Law. Federal regulation (42 CFR Part 2) prohibits 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.