COLGATE UNIVERSITY

Authorization for Release of Medical Information

1. I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

Email: _____ University ID#: _____

Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. RELEASE RECORDS: ☐ Mail records ☐ Fax records ☐ Hold for pick-up ☐ Discuss verbally

RELEASE RECORDS: ___ FROM or ___ TO ⇆	**RELEASE RECORDS: ___ FROM or ___ TO**
Colgate Student Health Services	Name/Organization _____
13 Oak Drive	Street Address _____
Hamilton, NY 13446-1398	City / State / Zip Code _____
Telephone: 315-228-7750 Fax: 315-228-6823	Phone _____/_____ Fax _____/_____
Email: studenthealth@colgate.edu	

3. INFORMATION TO BE RELEASED

		DATE OF SERVICE/CONTENT			DATE OF SERVICE/CONTENT
☐	Office visit	_____	☐	Lab/Test results	_____
☐	GYN visit	_____	☐	Radiology	_____
☐	Psychiatry	_____	☐	X-Ray image disk	_____
☐	Billing receipts	_____	☐	Entire Record	_____
☐	Immunizations	_____	☐	Other	_____

4. SPECIAL INSTRUCTIONS _____

5. REASON FOR RELEASE OF INFORMATION _____

6. SIGNATURE OF PATIENT (or representative authorized by law)

- I understand that signing this form is voluntary.
- Unless otherwise revoked, this authorization will expire on (date or event) _____.
- If I fail to specify an expiration date or event, this authorization shall remain valid for one (1) year from the date of my signature
- I may revoke this authorization in writing at any time, except to the extent that SHS has already acted on this authorization.
- I may revoke it by sending a written notice to Colgate Student Health Services at the address/fax number above.
- I understand that the records released may include information relating to HIV or AIDS. (See page 2 for information.)
- I understand that the records released may include information relating to treatment for or history of drug or alcohol abuse. If you do not want such information included, please write "exclude alcohol/drug information" on the "Special Instructions" area of this form.
- I understand that if the individual or organization authorized to receive the information is NOT a health plan or health care provider the released information may no longer be protected by federal privacy regulations.
- I release Colgate University from all legal responsibilities that may arise from the release of this information.

I have read and fully understand the above statements and consent to the disclosure of my health information for the purpose and to the extent stated above

Signature: _____ Today's Date _____

OFFICE USE ONLY:

Reviewed/Approved by: _____ Date: _____/_____/_____

Release of HIV-Related Information

Please be aware that the records you have authorized for release may include information relating to a discussion, testing, or treatment of HIV or AIDS.

If you do not want such information to be included in this release, please write "exclude HIV-related information" on the "Special Instructions" area of this form.

Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV infection, HIV related illness or AIDS, or any information that could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV-related information can only be given to people you allow to have it by signing a written release or to people who need to know your HIV status in order to provide medical care and services, including medical care providers; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals or other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

Redisclosure of HIV/AIDS, Alcohol or Drug Treatment, Mental Health Treatment Information

With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 18883923644. This agency is responsible for protecting my rights.