Medaille College Student Health Services
18 Agassiz Circle
Buffalo, NY 14214
Phone: 716-880-2112 Fax: 716-880-3399

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name_____ Date of Birth_____

Social Security Number_____ Student ID#_____

Address:_____
Street City State Zip

Phone:_____
(Home) (Cell)

The following individual, organization or facility is authorized to release information.

____ Medaille College Health Services, 18 Agassiz Circle, Buffalo, NY 14214

____ Other (specify) Name _____

Address _____

To the following organization or individual:

____ Medaille College Health Services, 18 Agassiz Circle, Buffalo, NY 14214

____ Other (specify) Name_____

Address _____

Information to be disclosed:

____ Immunization Records

____ Physical Examination

____ Nurses Notes date(s) _____

____ Complete Medical Record

____ Laboratory Results date(s) and Test(s) _____

____ X-Ray Reports date(s) and x-ray of: _____

____ Physician's Progress Notes date(s) _____

Reason for Disclosure:

____ Continued Medical Care

____ Legal

____Disability Support/Accommodation

____Counseling Support Services

____Registration at another college/university

____Work requirement

____Parent/Guardian Notification of illness/injury or current health status

____Medaille College Academic Dean for missed class

____Medaille College Faculty for missed class

____Medaille College Athletic Trainer for participation in sports

____Health Insurance Company for claims payment

____Other (specify): _____

This authorization will automatically expire in 180 days (6 months) unless the undersigned specifies another expiration date, event or condition as noted: _____

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.
The information disclosed pursuant to this authorization may be disclosed again by Recipient and, if so, may no longer be protected by Provider's privacy practices or federal privacy regulations.
By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

Signature of patient or legal representative _____Date _____

If signed by legal representative, relationship to patient: _____