GENESEO
THE STATE UNIVERSITY OF NEW YORK

Department of Student Health and Counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: ____________________________ Date of Birth:_____________ Geneseo ID Number: ____________

Student Phone #: _____________________ Email:______________________________

I authorize Student Health and Counseling **to RELEASE information TO:**	I authorize Student Health and Counseling **to OBTAIN information FROM:**
________________________________ Name of individual(s) or organization	________________________________ Name of individual(s) or organization
________________________________ Address	________________________________ Address
________________________________ City, State, Zip code	________________________________ City, State, Zip code
________________________________ Phone and Fax # (include area code)	________________________________ Phone and Fax # (include area code)

☐ Mutual exchange of information

This request applies to ☐ **Medical Records** ☐ **Counseling Records**

From date __________ To date ____________ (cannot be longer than one (1) academic year)

☐ Immunization record ☐ Physical exam/history ☐ Psychotherapy/treatment summary
☐ Consultation reports ☐ X-ray reports ☐ Laboratory test reports ☐ Visit verification
☐ Treatment Recommendations ☐ Other Information or Instructions (please specify): _________________________

I **do not** want to share ☐ AOD ☐ STI ☐ Other: ____

NOTE: Records pertaining to HIV tests/counseling require separate authorization for release.

Authorization:

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as contained in this authorization. I understand that this release pertains only to treatment provided by the authorized party (s), and does not include release of information received from other treatment providers.

I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. Signed releases of information, authorized by the patient, are time-limited, with written specified dates, and are diagnosis-related.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization.

Student Signature:____ Date:_________________________

Witness: ____ Date: __________________________

This information has been disclosed from confidential records. State law prohibits any further disclosure of this information without the specific, written consent of the person to whom it pertains or as otherwise permitted by law.

For Office Use only

Request Received: __________________________________ Documents Reviewed: _________________________________

Medical Reviewed: ____ Date _________________________

Counseling Review: ____ Date _________________________