Authorization to Release/Obtain Medical Records

The College of Saint Rose

Instructions:

(1) **Complete this entire form** to release/obtain medical records

(2) Please ***allow 3 business days*** for Health Services to process your request.

I hereby authorize the disclosure of information from the health records of:

Student's First Name	Student's Last Name	Former or Maiden Name

Phone # (with area code)	Student ID#	Date of Birth	Year Entered Saint Rose	Year Left Saint Rose

Health Information to disclose:

[ ] Immunization records [ ] Treatment records

[ ] Other (specify)_____

Method of disclosure:

[ ] release medical records **FROM** The College of Saint Rose Health Services **TO**:

Name:_____

Address:_____

FAX No.:_____

[ ] release medical records **TO** The College of Saint Rose Health Services, 432 Western Ave., Albany, NY 12203
FAX: 518.454-2007

FROM : Name:_____

Address:_____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____ _____

Signature of Student (Parent/Guardian if student is under 18). Date

_____

Relationship to student (Parent/Guardian/Executor)

OFFICIAL USE ONLY

Completed by_____ Date completed: _____

ID Presented:_____ Delivery Method: [ ] FAXED [ ] MAILED [ ] IN PERSON

File with record when completed