Student Name: (Print) ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Health and Wellness Center
P.O. Box 3050 Utica, NY 13504-3050
Phone: 315.792.7172 Fax: 315.792.7371

I ____________________ tifiable protected health information by any current employee of the SUNYIT Health & Wellness Center, or any other person/facility listed below to disclose my protected health information as described on this form to the person(s)/organization listed below. I retain the right to revoke this authorization at any time.

Authorization to: Release medical records TO a person/organization

I authorize SUNYIT to:

_____ Fax
_____ Mail
_____ Provide me
_____ Discuss

A copy of my: (Check all that apply)

_____ Immunization Record
_____ Physical Exam Record
_____ Accident/Injury Report
_____ Medical Record (specify) ____________________
____
_____ Other (specify) ____________________
____

To: Name(s) ____________________
Address ____________________
____
Phone Number ____________________
Fax Number (if applicable) (_______)____________________

Student Signature
____
Date ____________________

OR

Authorization to: Obtain medical information FROM a person/organization

I authorize: ____________________
Name of health care professional/Organization Address
____
Phone Number FAX Number (if applicable)

to: _____ Release medical information to health care professionals at the SUNYIT Health & Wellness Center by phone, fax, e-mail or as deemed necessary to provide proper medical care to me

_____ Release to SUNYIT a copy of my: (Check all that apply)

_____ Immunization Record
_____ Physical Exam Record
_____ Accident/Injury Report
_____ Most recent GYN Exam with pap smear results
_____ Medical Record (specify) ____________________
____
_____ Other (specify) ____________________
____

_____ Release to SUNYIT my medical, insurance and/or billing information regarding my health insurance coverage and claim submission

Student Signature ____________________
Date ____________________

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