THE COLLEGE AT BROCKPORT
STATE UNIVERSITY OF NEW YORK

HAZEN HEALTH CENTER
350 NEW CAMPUS DRIVE
BROCKPORT, NEW YORK 14420
PHONE: (585) 395-2414
FAX: (585) 395-2559

CONSENT FOR RELEASE OF INFORMATION

I, _____, do hearby grant authorization to The College at Brockport, Hazen Student Health Center to:

_____ Release to: **_____Obtain from:**

_____
Name of person to receive or release information

_____
Complete Address and Zip Code

_____
Fax Number

The following information as checked below concerning the treatment of:

_____ _____ _____
Patient Name **Date of Birth** **Phone #**

_____ _____
Address and Zip Code **S.S. # or Banner ID#**

_____**Progress notes from:**_____
_____**Laboratory reports from:**_____
_____**X-ray from:**_____
_____**X-ray reports from:**_____
_____**Immunization record:**_____
_____**Physical form:**_____
_____**Other:**_____

Reason for request: _____

I understand that according to Federal and State laws, this release does not include permission to transmit information specifically related to HIV status, and if such information is to be released additional specific release forms are required. I understand that this consent is valid for one full calendar year From the date of signing, and that I may rescind this consent at any time with written notification.

_____ _____ _____
Signature of Student **Witness Signature** **Date**

Consent Expiration Date_____

Date Faxed:_____ **Date Copy given:**_____

Date Mailed:_____ **Processed by:**_____