



AUTHORIZATION FOR RELEASE OF MEDICAL, AND/OR BEHAVIORAL HEALTH INFORMATION

Please print clearly. Ensure that all numbered boxes on this form are completed.

1 **Client name:** _____ **Date of Birth:** ___/___/___
Address: _____
Phone Number: () _____ **Banner ID:** _____

2 **Select all of the following types of authorization that apply.** Psychiatric and alcohol/drug treatment records are not included in this authorization unless you complete the following section giving specific permission to do so.

Medical/Surgical/Dental Information Psychiatric Information Alcohol/Drug Abuse Information

3 **This authorization allows The College at Brockport to:**

RELEASE copies of your record to (or discuss information with) the Provider/Person/Facility below
 Name of Provider/Person/Facility: _____
 Address: _____
 Phone: () _____ Fax: () _____

AND/OR

OBTAIN copies of your record from (or discuss your information with) the Provider/Person/ Facility below
 Name of Provider/Person/Facility: _____
 Address: _____
 Phone: () _____ Fax: () _____

4 **Purpose and need for release:**

Treatment Legal Insurance Coverage Personal Other _____

5 **This information may be released by:**

Copy Court Testimony Electronic Means Fax Verbal Means
 Other _____

6 **I authorize the release of the following health information and/or medical records, if such information exists:**

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Operation Report	<input type="checkbox"/> Educational Information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Psychiatric Information	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medical Information
<input type="checkbox"/> Assessments	<input type="checkbox"/> Lab Test Results	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Other _____

7 This authorization covers treatment period(s): *(Please select "all episodes" or indicate specific treatments, but not both.)*

Treatment related to: _____

OR All episodes of care

8 Use/disclosure frequency: *(Check ONE)*

One time Use/ Disclosure: I hereby permit the one-time use of the information described in boxes 6 and 7 to the provider/ person/ facility named in box 3.

Periodic Use/ Disclosure: I hereby permit the periodic use or disclosure of the information described in boxes 6 and 7 to the provider/ person/ facility named in box 3 as often as necessary to fulfill the purpose identified above in box 4.

Expiration Date: *(Check ONE)*

This authorization will remain in effect until:

Ninety (90) days after discharge from treatment **OR** Other: _____
(Specify expiration date or expiration event.)

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date of discharge.

9 I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may revoke this authorization at any time by submitting a written request to the address provided on this form. I understand that the cancellation will not apply to the information already released in response to this authorization.
- If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations the information indicated above could be re-disclosed.
- Psychiatric and alcohol/drug treatment information is protected under Federal and State Regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further disclosure is prohibited by law.
- The release of HIV-related information requires additional authorization.

10 Signature of client: _____ Date: ____/____/____

11 Signature of legal client representative: _____

Print name: _____ Date: ____/____/____

Contact information: _____

Relationship to client: Parent Legal guardian Other _____

12 Witness of signature: _____ Date: ____/____/____

Office Use Only: Method Sent: Fax Mailed Copy to patient

Date Completed ____/____/____ Processed by: _____