

# ROCHESTER INSTITUTE OF TECHNOLOGY

STUDENT HEALTH CENTER  
117 LOMB MEMORIAL DRIVE  
ROCHESTER, NEW YORK 14623  
PHONE: (585) 475-2255 FAX: (585) 475-7788

## **Authorization for Release of Medical Information**

Patient Name: _____	Date of Birth: _____
Address: _____	
City/State/Zip Code: _____	
Patient Phone #: _____	Email: _____ University ID#: _____

I authorize RIT Student Health  
to **RELEASE** information to:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
Phone and Fax # (include area code)

I authorize RIT Student Health  
to **OBTAIN** information from:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
Phone and Fax # (include area code)

**This request applies to:**

- Immunization Record     Psychiatric Records     GYN Records     Substance Abuse/Alcohol Records  
 Specific Office Visit on \_\_\_\_\_ (date)     Lab/Test results on \_\_\_\_\_ (date)  
 All Healthcare Information

**Purpose of disclosure of information:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Please Note: There is a \$0.75 per page fee when requesting medical records**

<b>OFFICE USE ONLY:</b>			
Reviewed by: _____	Date: _____	Approved by: _____	Date: _____
Copied and sent/faxed by: _____	Date: _____		
Payment Received Date: _____			

