ROCHESTER INSTITUTE OF TECHNOLOGY
STUDENT HEALTH CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Form must be completed in its entirety for all authorizations:
I give my authorization to disclose my protected health information as described below, limited to the amount reasonably necessary to achieve purpose of disclosure or request. I give this authorization voluntarily. I understand that if the organization authorized to receive the information is NOT a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:___________________________________ **DOB:**_____ **ID Number**__________________________

Persons/organizations **PROVIDING** the information: (Provide full address or fax number)	Persons/organizations **RECEIVING** the information (Provide full address or fax number)
____	____
____	____
____	____
____	____

Specific description of information to be disclosed:

- ☐ Immunization Record
- ☐ **Specific** Office Visit on ____________ (date)
- ☐ Lab/Test results________________ (date)
- ☐ All Medical Records
- ☐ HIV/AIDS (NYS release required)
- ☐ Substance Abuse/Alcohol
- ☐ Psychiatric Records
- ☐ GYN Records
- ☐ Other: ____

Purpose for disclosure of information:____

If Student Health Center is requesting protected health information from another provider or facility, I understand that I may request to see the information described if I ask for it. (initials)___________

I have read this form and understand it, and all my questions have been answered.

Patient Signature ____Date_______

Witness Signature ____Date_______

Reviewed/approved by ________________ Date_______ Copied and sent/faxed by _____________Date_______

Please send records to: RIT Student Health Center Attention:______________________________________
117 Lomb Memorial Drive Rochester, New York 14623
V/TTY: (585) 475-2255; Fax (585) 475-7788

ECJ: 1984: rev 11/93, 5/94, 4/97, 9/01, 3/02, 1/03, 12/03, 6/06