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:**	I authorize RIT Student Health **to OBTAIN information FROM:**
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip code	_____ City, State, Zip code
_____ Phone and Fax # (include area code)	_____ Phone and Fax # (include area code)

This request applies to:

☐ Immunization Record (free copy) ☐ 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: The fee for records is $0.75 per page. A copy of your immunization record is given at no cost.**

OFFICE USE ONLY:
Reviewed/Approved by: _____ Date: _____ Copied and sent/faxed by: _____Date: _____

Form must be completed in its entirety for all authorizations:

I give my authority to disclose my protected health information as described above, 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.