RIT | Division of Student Affairs
Student Health

Rochester Institute of Technology
117 Lomb Memorial Drive
Rochester, NY 14623
Tel: 585-475-2255
Fax: 585-475-7788

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ _____ **UID:** _____
First Name Last Name
DOB: _____
Phone: _____ **Email:** _____
Address: _____ _____

☐ I authorize RIT Student Health Center to RELEASE information TO:
☐ I authorize RIT Student Health Center to OBTAIN information FROM:

_____
Name of Provider or Facility

_____
Address

_____
City/State/Zip Code

_____ _____
Phone Number Fax Number

This request applies to the following:

☐ Immunization Record ☐ Psychiatric Record ☐ GYN Records ☐ All Healthcare Information

☐ Specific office visit on: _____ ☐ Lab test results from: _____
Date Date

All information from:
☐ Case Management ☐ Counseling and Psychological Services ☐ Student Health Center

☐ Only the following information: _____

_____

Purpose of disclosure of information: _____

_____

The release of information is valid through: _____ (valid one year after signature date if blank)

I understand that this information will be regarded as strictly confidential by all persons involved. I also understand that I may withdraw my permissions at any time and this authorization will expire if there is a date indicated above.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

OFFICE USE ONLY:

Reviewed/Approved by:_____Date:_____Copies/Sent by:_____Date:_____Mail:_____Fax:_____Phone:_____