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: _____

Phone: _____ DOB: _____

Address: _____ Email: _____

City/State/Zip Code: _____

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

_____
Name of Provider or Facility

_____
Address

_____
City/ State/ Zip Code

_____
Phone and Fax Number

I authorize RIT Student Health Center to **OBTAIN** information **FROM**:

_____
Name of Provider or Facility

_____
Address

_____
City/ State/ Zip Code

_____
Phone and Fax Number

This request applies to the following:

_____Immunization Record _____ Psychiatric Records _____GYN Records _____ All Healthcare Information

_____ Specific Office Visit on: _____ Date _____Lab test results from: _____ 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 if 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 permission 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: _____