CANISIUS COLLEGE STUDENT HEALTH CENTER

2001 Main Street, Buffalo, NY 14208
Phone: (716) 888-2610 Fax: (716) 888-3217

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name				Date of Birth	College ID#
Address:	City	State	Zip Code	Home Phone Number	Cell Phone Number

The following individual, organization or facility is authorized to release information

□ Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208
□ Other (specify) **Name:** _____

Address: _____

The information may be disclosed to and used by the following organization or individual

□ Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208
□ Other (Specify) **Name:** _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

Information to be Disclosed:

□Immunization Records _____
□Physical Examination _____
□Progress Notes Date(s) _____
□Complete Medical Record _____
□Other _____
_____

□Laboratory Results Date(s) and Tests: _____
□X-ray Reports Date(s) and X-ray of: _____
□Other Diagnostic Reports Date(s) and Study: _____
□Emergency Room Report Date(s): _____
□Discharge Summary Date: _____
□Current Health Condition (specify condition): _____

Reason for Disclosure:

□Continued Medical Care
□Legal
□Disability Support/Accommodation
□Counseling Support Services
□Registration at another College/University
□Work Requirement
□Parent/Guardian Notification of Illness/Injury /Current Health Status
□Canisius College Academic Dean for Missed Class
□Canisius College Faculty for Missed Class
□Canisius College Athletic Trainer for Participation in Sports
□Health Insurance Company for Claims Payment
□Other (specify): _____

This authorization will automatically expire in 180 days (6 months) unless the undersigned specifies another expiration date, event or condition as noted: _____

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to the provider. However, any revocation shall not apply to the extent that the provider has taken action in reliance on this authorization. The information disclosed pursuant to this authorization may be disclosed again by the recipient and if so, may no longer be protected by the provider's privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

Signature of patient or legal representative: _____ **Date**: _____

If signed by legal representative please indicate relationship to patient: _____

Release of Information Authorized by

Director of Student Health, Canisius College-Buffalo, New York
Tracie Barletta, MSN, FNP-BC Initials _____ ***Date*** _____