Davis Health Center - Campus Center 004 - Canton, NY 13617
Phone: (315) 386-7333 Fax: (315) 386-7932

Authorization for Release of Protected Health Information

I hereby authorize _____ to disclose the following information from the health records of:

Patient Name:_____SS# or ID# _____DOB _____

Address:_____Telephone: _____

_____Semester & year last attended _____

Information to be disclosed: (Please check)
Note: Mental Health records and HIV Tests require a separate authorization for release

_____ History & physical examination
_____ Consultation reports
_____ X-ray reports
_____ Records pertaining to STD's
_____ Other (please specify) _____
_____ Immunization records
_____ Laboratory tests
_____ Alcohol and Drug Abuse Records
_____ Copy of last Annual GYN Exam and Pap Smear

If applicable: The period(s) of health care: From (date) _____ to _____

Purpose:_____
Information to be release to:

Name: _____
Address: _____
City: _____State: _____ Zip: _____
Telephone: _____ Fax: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 1 year from the date signed or on the following date:

_____
(Please put in date, i.e., 30 days)

The office or agency releasing the information is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patient Signature Date

_____ _____
Signature Legal Representation Relationship to Patient Date

_____ _____
Signature of Witness Date

For Official Use

Done by: _____ Date: _____