Campus Health Services
Tel (315) 655-7122
Fax (315) 655-4724

CONSENT FOR RELEASE OF INFORMATION

I, _____, do hereby grant authorization to Cazenovia College Health Services to Release to/Obtain from:

_____
Name of Person to receive or release information

_____
Address City State Zip Code

The following information as checked below concerning the treatment of:

_____ ___/___/___
Patient Name Date of Birth

_____
Address City State Zip Code

___ Progress Notes From _____
___ Lab Reports From _____
___ X-Ray Reports From _____
___ Immunization Records _____
___ Physical Exam From _____
___ GYN Exam/Pap From _____

Reason for request: _____

I understand that in accordance with Federal and State laws, this release does not include permission to transmit information specifically related to HIV (Human Immunodeficiency Virus, the causative agent of AIDS) status or personally sensitive information unrelated to my request and if such information is to be released, additional specific release forms are required. I understand that this consent is valid for ninety (90) days from the date of signing, and that I may rescind this consent at any time with written notification. Cazenovia College Health Service employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Date: _____ _____
Signature of Legal Representative

_____ _____
Signature of Patient/Student Signature of Witness