

# Student Health Services

## University at Buffalo

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Date Received – Official Use Only

### Authorization to Release/Obtain Medical Records

#### Instructions:

- (1) Complete this entire form to release/obtain medical records.
- (2) **Please allow two-weeks for Student Health Services to process your request.**

#### I hereby authorize the disclosure of information from the health records of:

Patient's First Name		Patient's Last Name		Former or Maiden Name	
Phone Number (with area code)	UB Person Number	Date of Birth	Year Entered UB	Year Left UB	

#### Health Information to disclose:

- |   |   |
|---|---|
| <input type="checkbox"/> all information      | <input type="checkbox"/> labs & imaging studies                 |
| <input type="checkbox"/> treatment summary    | <input type="checkbox"/> dates of treatment attendance          |
| <input type="checkbox"/> diagnoses            | <input type="checkbox"/> progress note entries - date(s): _____ |
| <input type="checkbox"/> immunization records | <input type="checkbox"/> other (specify) _____                  |

#### Method of disclosure:

- release medical records from UB Student Health Services to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
or Fax No.: \_\_\_\_\_

- release medical records to UB Student Health Services from:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
or Fax No.: \_\_\_\_\_

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: \_\_\_\_\_.

Signature of Patient or Parent/Guardian/Executor

Date

Relationship to Patient (Parent/Guardian/Executor)

This form cannot be used for the re-release of confidential information provided to Student Health Services by other individuals or agencies. Such requests should be referred to the original individual or agency. Records pertaining to HIV tests or discussions or alcohol/drug treatment require separate authorizations.

Official Use Only

File with record when completed

Completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_ Delivery method:  FAXED  MAILED  IN PERSON 7/2006