Syracuse University Authorization for the Release of Records

Full name of student: SU ID:

Student's date of birth: Student's telephone number:

Student's address:

City: State: Zip:

I understand that my health records maintained by Syracuse University and personal information therein are confidential and will not be disclosed without my prior written consent, unless otherwise required or permitted by law. I understand that by completing this form, I am voluntarily authorizing the release of my confidential records or personal information, as described herein, to parties who have a demonstrable need for the information.

I authorize the Syracuse University Barnes Center at The Arch Health and Counseling to release confidential records and information (as identified below) to the following person(s) or entity, which has a demonstrable need for the information:

Name of person, organization or agency:

Address:

City: State: Zip:

Telephone number:

Fax number:

Specific Records or Information to be Released

- ☐ Health Records, including without limitation, patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers, (insert dates) from _____ to _____ .

- ☐ Include (initial to release this information):

  - ☐ Sexual Assault

  - ☐ Alcohol/Drug Treatment

  - ☐ HIV-Related Information

- ☐ Counseling or Mental Health Records, including, without limitation, treatment plans, substance abuse evaluations, attendance records, progress in treatment, recommendations, discharge summary,(insert dates) from _____ to _____ .

- ☐ Other: _____

Reason for Release of Treatment Records

- ☐ At request of student.

- ☐ Referral or treatment.

- ☐ Legal or judicial.

- ☐ Other: _____

Date or event on which this authorization will expire:

I hereby permit the use or disclosure of the above information to the person(s) or entity identified above. I understand that:

1. Only the information described herein may be used or disclosed as a result of this Authorization.
2. This authorization may include disclosure of information relating to sexual assault, alcohol/drug treatment, mental health treatment and HIV related information only if I place my initials on the appropriate line in the box above. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.
3. To administer release of my records, school officials other than my treatment provider may need to compile and review my records. This includes administrative staff and, in some cases, legal counsel.
4. I may revoke this Authorization at any time by notifying Syracuse University in writing. I am aware that my revocation will not be effective if action has already been taken as authorized herein.
5. I do not have to sign this Authorization and my refusal to sign will not affect my abilities to obtain treatment.
6. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2.) and this re-disclosure may no longer be protected by federal or state law.
7. All of my questions about this form have been answered.

I authorize Syracuse University to release the specified records or information by fax or mail to the aforementioned person, organization or agency.

Date:

Signature of Patient or Personal Representative:

Patient's Full Name (Printed):

Personal Representative's Full Name (Printed):

Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization):