STUDENT HEALTH SERVICES
715 North Avenue • New Rochelle, NY, 10801-1890
Phone: (914) 633-2548 • Fax: (914) 712-4102

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Iona College Student Health Service to disclose my protected health information.

To disclose the health information for the following patient:

Last Name: _____

First: _____ Middle Initial:_____

Date of Birth:_____

Address: _____

City: _____

State:_____ Zip Code:_____

Phone ( )_____

Email: _____

To the following individual or organization:

Name:_____

Address: _____

City: _____

State:_____ Zip Code:_____

Fax: ( )_____

Purpose of the disclosure:

☐ Planning and/or coordination of ongoing care

☐ Transfer to another academic institution

☐ Insurance reimbursement

☐ Legal matter

☐ Other _____

Information to be Disclosed:

Please check the appropriate sections of the health record to be released (check all that apply):

☐ Records only related to the following date(s) of service:_____

☐ Medical Clinic Note(s)

☐ Lab Reports

☐ Immunization Records

☐ Women's Health: ☐ Clinical Notes ☐ Lab Work

☐ Records which may indicate the presence of a communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS treatment, testing, or discussion _____(Initial).

☐ Physical Exam

☐ X-ray Report

I understand that:

- I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of such information. It is possible that, once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
- Unless otherwise revoked, this authorization will expire on (date or event) _____.
  If I fail to specify an expiration date or event, this authorization with expire one (1) year from the date of my signature.

I have read and understand the information in this authorization form. I also release Iona College Student Health Service from any liability or legal responsibility in connection with the release or the above information and the risk and consequences of faxing health information.

Signature:_____ Initials:_____

Print Name:_____ Date:_____