Authorization to Release Information

SUNY Cobleskill Wellness Center
130 Albany Avenue • Cobleskill, New York 12043
Phone: 518-255-5225 • Fax: 518-255-5819

Name: ID#: DOB:
(Last) (First) (MI) (mm/dd/yy)

Authorization for information to be released by:

☑ SUNY Cobleskill Wellness Center

☐

(Name of individual / Title / Relationship or Organization

(Address/Phone/Fax)

Information to be released to:

☐ SUNY Cobleskill Beard Wellness Center - Attn:

☑ SUNY Cobleskill Religious Exemption Review Committee
(Name of individual / Title / Relationship or Organization)

(Address/Phone/Fax)

Do not disclose information regarding: ☐ HIV ☐ Alcohol /drugs ☐ Pregnancy

Information to be released:

- ☐ Complete medical/treatment record
- ☐ Consultation reports
- ■ Immunization record
- ☐ X-ray reports
- ☐ Physical Exam history
- ☐ Laboratory results
- ☐ Psychotherapy/treatment summary
- ☐ Treatment recommendations
- ☐ Verification of visit on: _____
- ☐ Verbal communication regarding:_____
- ☐ Other information or instructions (please specify):_____

Records pertaining to HIV tests/counseling require separate authorization for release.

Comment

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as contained in this authorization. I understand that this release pertains only to treatment provided by the authorized parties, and does not include release of information received from other treatment providers. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. 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 on the following date: _____, or 1 year from the date of the request if no date is specified.

As a result of COVID-19 restrictions, I have given verbal consent and am electronically signing this document with my name and campus identification number authorizing the release of information as indicated above.

Electronic Signature **Date**

800 Number