Request for Release of Medical Information
From SUNY College of Fredonia

Name:___________________________ Fredonia Number: ______________
Permanent Address:_________________ Birthdate:________________________
_________________________________ Phone: __________________________
Local Address:______________________ _________________________________

I, ___________________________________, authorize SUNY Fredonia to release the following information from my medical records:

____Clinical Notes Dated From:_____To:____
____Lab Work/X-ray Records Only
____Immunization Record Only
____Other:____________________________

Records to be mailed to:

Name:____________________________
Address:__________________________
____
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I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I understand that this authorization may be revoked by me at any time in writing, and that it will automatically expire after 90 days from the date of the signature unless otherwise specified.

Signed: ______________________________ Witness:_________________________

Prohibition on redisclosure:
I understand the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or disclosure is specifically required or permitted by law.