

**Request for Release of Medical Information
To SUNY College of Fredonia**

Name: _____ S.S.#(last four digits) _____
Permanent Address: _____ Birthdate: _____
_____ Phone: _____
Local Address: _____

I, _____, request the release of the following information from my Medical Records from the following Medical Office or Agency:

Name of Physician or Agency: _____
Address: _____
Phone Number: _____

Please include:

_____ Clinical Notes Dated From: _____ To: _____
_____ Lab Work/X-ray/Diagnostic Test Reports (specify): _____

_____ Immunization Record Only
_____ All available records

Records to be mailed or sent to:

LoGrasso Hall Health Center
SUNY College at Fredonia
Fredonia, NY 14063
Fax: 716-673-4722
Phone: 716-673-3131

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.