Syracuse University Health Services
111 Waverly Avenue
Syracuse, NY 13244
Phone: 315.443.9005 Fax: 315.443.9010

AUTHORIZATION FOR THE RELEASE OF TREATMENT RECORDS

Student Name	Date of Birth	SU ID
Student Address	Telephone Number	
City, State Zip		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to sexual assault**,** alcohol/drug treatment, mental health treatment (with the exception of psychotherapy notes) and HIV related information only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. 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. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. 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.

6. **I authorize Syracuse University Health Services to** (select only one)_____Disclose records to_____Obtain records from

Name/Organization:_____

Address:_____ **Telephone: ( )**_____

City/State/Zip:_____ **Fax: ( )** _____

7. Specific information to be released:
   - ☐ Treatment Records from (insert date)_____to (insert date)_____
   - ☐ Entire Treatment Record, including patient histories, office notes, test results, lab & radiology, referrals, consults and billing.
   - ☐ SUA Patient Care Report
   - ☐ Other:_____

Include: (Initial to release this information)
_____Sexual Assault
_____Alcohol/Drug Treatment
_____Mental Health Treatment
_____HIV-Related Information

Authorization to Discuss Health Information

7b.

By initialing here_____authorize_____
Initials — Name of Individual health care provider

to discuss_____with the individual(s) or agency listed here:

_____
(Individual/Attorney/Firm Name/Governmental Agency Name)

8. Reason for release of treatment records:	10. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
9. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____
Signature of patient or representative authorized by law — Date