St. Bonaventure University

Center for Student Wellness

Release of Medical Information

I hereby give my authorization for The Center for Student Wellness to exchange/receive the information indicated below with the following provider/person/organization regarding my healthcare. This includes permission to make photocopies and/or examination of the records.

Party to release information:

Name: _____Relation to student:_____

Address: _____

_____

Phone: _____ Fax: _____

Party to receive information:

St. Bonaventure University, Center for Student Wellness
PO Box 2469 Doyle Hall
St. Bonaventure, NY 14778
716-375-2310; Fax: 716-375-7892

Information to be exchanged:

- ☐ Admission/discharge dates
- ☐ Demographic information
- ☐ Assessment
- ☐ Presence in treatment
- ☐ Progress in treatment
- ☐ Immunization records
- ☐ Laboratory/testing results
- ☐ Treatment plan
- ☐ Aftercare plan
- ☐ Insurance information
- ☐ OTHER: _____
  _____

Purpose of disclosure:

- ☐ Family involvement
- ☐ Employer Involvement
- ☐ Discharge/aftercare planning
- ☐ Other: _____
  _____
- ☐ Continuity of care
- ☐ Insurance/payment
- ☐ Legal issues

Method of disclosure:

- ☐ Mail
- ☐ Fax
- ☐ Telephone
- ☐ Interview
- ☐ Hand delivered by:
  _____

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This authorization will expire thirty (30) days after the date of termination of services from the Center for Student Wellness unless otherwise noted. This release of information is limited to the person/organization named above and will not be used for any purpose other than that stated. This authorization is fully understood by me and is made voluntarily on my part.

Printed Name of Student/Client: _____ Phone #: _____

Date of Birth: _____Last year/semester attended SBU/other school: _____ Student ID: _____

_____ _____

Signature of Student/Client **Date/Time**

_____ _____

Witness Signature **Date/Time**

By signing this authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner described on this form. Except as authorized by this form, we are required by law under the Federal Educational Rights and Privacy Act to maintain the privacy of your health information.

Refusals of Service

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide service IF you refuse to sign this authorization. Otherwise, your ability to receive treatment does not depend on you signing this form. You may refuse to sign this form.

Consequences of Signing This Form

Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protections of federal privacy laws. Any person or organization to whom your health information is disclosed pursuant to this authorization might be able to legally re-disclose that information to others.

Revocation of Authorization

You may revoke this authorization at any time except to the extent to which the Center for Student Wellness has already relied upon it in making a disclosure to the named party on this form. Your verbal revocation will become effective when we have knowledge of it. At this point, staff will document the verbal revocation in writing. You may also request, in writing, that this authorization be revoked by writing to the following:

Center for Student Wellness
St. Bonaventure University
PO Box 2469 Doyle Hall
St. Bonaventure, NY 14778

If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke this authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy.

Expiration of Authorization

This authorization will automatically expire thirty (30) days post-termination of services unless otherwise dated here: _____.

You have a right to a copy of this authorization at any time.

☐ Accepted ☐ Declined