Center for Student Wellbeing
3261 West State Road, St. Bonaventure, NY 14778
Phone: 716-375-2310 *Fax:* 716-375-7892

Consent for Release of Confidential Information

Name:_____ Date of Birth: _____

Other Names Used: _____ Phone:_____

☐ Current Student ☐ Not Current Student, last year of attendance:_____

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 **ALCOHOL** and **DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, and **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** only if I place my initials on the appropriate line. In the event the health information described below includes any of these types of information, and I initial the line in the box, I specifically authorize release of such information to the person(s) indicated.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the 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. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

RELEASE INFORMATION:

T O	Person or Facility:		F R O M	Person or Facility:
	Address:			Address:
	Phone:			Phone:
	Fax:			Fax:

INFORMATION TO BE RELEASED:

☐ ALL records	☐ Immunization Records	☐ Labs (except HIV/AIDS-related)	☐ Other:

****TO BE INCLUDED *ONLY* IF INITIALED:**

	Psychotherapy/Mental Health		Alcohol/Drug Abuse		HIV/AIDS-related		STI/Sexual Health

Purpose of Disclosure: _____

Expiration Date: □ 1 year from date signed □ Or Expires On:_____

_____
Signature of Patient or Representative Authorized by Law Date

_____
Witness Signature Date

***This information has been disclosed to you from confidential records which are protected by State and Federal law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure. ***