St. Bonaventure University Center for Student Wellness
3261 West State Road, St. Bonaventure, NY 14778
716-375-2310 (office) 716-375-7892 (fax)

Consent for Release of Confidential Information

Name:_____ DOB:_____

Other Names Used:_____

☐ Current Student ☐ Not Current Student (last year of attendance ____)

I, the undersigned, hereby authorize the Center for Student Wellness at St. Bonaventure University to disclose/obtain the following information with the agencies or professionals below (please check and initial on the line for any that apply):

☐ Medical Progress Notes __ ☐ STI Testing/Results __

☐ Psychological/Counseling Progress Notes __ ☐ Laboratory Reports __

☐ Health History/Physical Exam __ ☐ Immunizations __

☐ Psychiatric Evaluation __ ☐ Social History __

☐ Psychiatric Progress Notes __ ☐ Educational History __

☐ Alcohol &/or Other Drug Treatment __ ☐ HIV/AIDS __

☐ Other Information (please specify) _____

Purpose of Disclosure: _____

Expiration Date (expiration occurs automatically one year from date of signature): _____

Agency/Organization/Provider Name :_____

Address:_____

Phone/Fax:_____

I understand that this authorization applies to the individual(s) listed above and I may revoke this authorization at any time by notifying my Wellness Center provider or the Associate Dean for Student and Community Wellbeing. If I revoke authorization, I understand that it will not have any effect on any action/communication that was done prior to the revocation. I acknowledge that this authorization is given voluntarily. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment. The Wellness Center employees and contracted designees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Print Name: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____