St. Bonaventure University

Center for Student Wellness

Release of Medical Information/Records Request

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. I also affirm that I understand that there are limits to what may be released to me or other parties including but not necessarily limited to information which originates with a healthcare provider or facility other than St. Bonaventure Center for Student Wellness.

Party to release information:

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

Party to receive information:

Name: _____Relation to Student:_____

Department: _____ Address: _____

_____

Phone: _____ Fax: _____

Information to be exchanged:

***Only information originating at SBU/CSW**

- ☐ Demographic information
- ☐ Mental/Physical Assessments
- ☐ Presence/progress in treatment
- ☐ Provider notes
- ☐ Counseling Services full record*
- ☐ Laboratory/testing results
- ☐ Treatment plan
- ☐ Aftercare plan
- ☐ Insurance information
- ☐ Immunization record
- ☐ Health Services full record*
- ☐ 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: _____

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 Health Insurance Portability and Accountability 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 acknowledgement 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:

St. Bonaventure University
Center for Student Wellness
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.

Scope, Revocation, and Expiration of Authorization

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. Unless an "alternate expiration date" is stated below, this authorization will expire thirty (30) days after graduation or after the student is no longer enrolled at SBU. This form will remain valid for students taking a temporary leave from St. Bonaventure, but will expire thirty (30) days following conversion of the leave to a full institutional withdrawal. 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.

Alternate expiration date: _____.

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

☐ Accepted at time of signing ☐ Declined at time of signing

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

Last yr & semester attended SBU or Other School: _____ Student ID #: _____

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

_____ _____
SBU Staff or Notary Signature (with stamp) **Date/Time**