SUNY Poly Wellness Center
100 Seymour Road
Utica, NY 13502
Phone: 315.792.7172
Fax: 315.792.7371

SUNY POLYTECHNIC INSTITUTE

Student Name: (Print) _____

Student ID #: _____

Date of Birth: _____

I authorize the use or disclosure of my individual identifiable protected health information by any current employee of the SUNY Poly Wellness Center, or any other person/facility listed below to disclose my protected health information as described on this form to the person(s)/organization listed below. I retain the right to revoke this authorization at any time.

Authorization for SUNY Poly to: Release medical records **TO** a person/organization

I authorize SUNY Poly to:

_____ Fax
_____ Send/Mail
_____ Provide me
_____ Discuss

A copy of my: (Check all that apply)

_____ Immunization Record
_____ Physical Exam Record
_____ Accident/Injury Report
_____ Medical Record (specify) _____

_____

_____ Other (specify) _____

_____

To: Name(s) _____
Address _____

_____

Phone Number _____
Fax Number (if applicable) (_____)_____

Student Signature _____
Date _____

OR

Authorization for SUNY Poly to: Obtain medical information **FROM** a person/organization

I authorize: _____
Name of health care professional/Organization Address

_____
Phone Number FAX Number (if applicable)

to: _____ Release medical information to health care professionals at the SUNY Poly Wellness Center by phone, fax, e-mail, or as deemed necessary to provide proper medical care to me

_____ Release to SUNY Poly a copy of my: (Check all that apply)

_____ Immunization Record
_____ Physical Exam Record
_____ Accident/Injury Report
_____ Most recent GYN Exam with pap smear results
_____ Medical Record (specify) _____

_____

_____ Other (specify) _____

_____

_____ Release to SUNY Poly my medical, insurance and/or billing information regarding my health insurance coverage and claim submission

Student Signature _____
Date _____