

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



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.

<p>Authorization for SUNY Poly to: <u>Release medical records TO a person/organization</u></p> <p>I authorize SUNY Poly to: _____ Fax _____ Send/Mail _____ Provide me _____ Discuss</p> <p>A copy of my: (Check all that apply) _____ Immunization Record _____ Physical Exam Record _____ Accident/Injury Report _____ Medical Record (specify) _____ _____ Other (specify) _____</p> <p>To: Name(s) _____ Address _____ Phone Number _____ Fax Number (if applicable) (_____) _____</p> <p>Student Signature _____ Date _____</p>	OR	<p>Authorization for SUNY Poly to: <u>Obtain medical information FROM a person/organization</u></p> <p>I authorize: _____ Name of health care professional/Organization _____ Address _____ Phone Number _____ FAX Number (if applicable) _____</p> <p>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</p> <p>_____ 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) _____</p> <p>_____ Release to SUNY Poly my medical, insurance and/or billing information regarding my health insurance coverage and claim submission</p> <p>Student Signature _____ Date _____</p>
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