

Counseling Services _____
Health Services _____

Alfred State

SUNY College of Technology

Student ID	_____
Date of Birth	_____

ALFRED STATE
Phone: 607-587-4200
Consent for the Release of
Confidential Information
TWO-WAY

I, _____, hereby authorize Alfred State Health and Wellness Services to disclose/receive records to/from _____

mail (provide address) or email (provide email) _____ the following information:

- History
 Assessment
 Treatment plan
 Progress with treatment
 Immunization record
 History and physical examination
 Other (please specify) _____

The purpose of the disclosure authorized in this consent is to: _____

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R part 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that it will automatically expire after 90 days from the date of the signature unless otherwise specified.

I understand that generally Alfred State may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Date _____

Signature of Client

Signature of parent, guardian, or authorized representative (when required)

Signature of Witness

Date

I hereby CANCEL my authorization to release the information outlined in this form.

Signature of Client

Date

Signature of Witness

Date

FOR OFFICIAL USE

DONE BY _____

DATE _____