Counseling Services _____

Health Services _____

Student ID	
Date of Birth	

ALFRED STATE COLLEGE
Consent for the Release of
Confidential Information
TWO-WAY

I, _____, hereby authorize Alfred State Health & Wellness Services to

disclose to/receive from _____

(FAX: _____) the following information:

☐ History ☐ Assessment ☐ Treatment Plan ☐ Progress with Treatment

☐ Immunization Records ☐ 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. parts 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 College 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 _____