BINGHAMTON UNIVERSITY
DECKER STUDENT HEALTH SERVICES CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name_____Date of Birth_____B-Number_____
(print clearly)
Former or Maiden Name_____Year Entered BU_____Year Left BU_____

Home Address_____

Email_____Phone/Cell_____

Information to be released by ☐ mail ☐ fax ☐ phone to:

Name_____

Relationship to Student _____

Address_____

Phone_____ Fax _____

I hereby authorize the Decker Student Health Services Center at Binghamton University to disclose the following information from my health record:

- ☐ **Immunizations/Health Form**
- ☐ **Lab/X-Ray Results – Date(s) authorized for release: _____**
- ☐ **Other: (Include nature and date(s) of illness/injury):**

I understand that this authorization may be revoked by me in writing at any time except to the extent that action has been taken based upon this authorization. Unless otherwise revoked, this authorization will expire on the following date or 6 months from the date of the request if no date is specified. **Expiration Date: _____**

I understand that authorizing the disclosure of my health information is voluntary and not a condition for treatment I understand that any release of information carries with it the potential for unauthorized disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient Signature Date

Completed form may be mailed to:
Decker Student Health Services Center
Binghamton University
PO Box 6000
Binghamton, NY 13902-6000
Fax: 607.777.2881
Phone: 607.777.2221

<u>Please allow seven business days to process requests for records</u>. During times of heavy volume at the beginning of each semester, allow extra processing time for record requests.