

**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 pick up phone to: _____ email 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 6 months from the date of the request.

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**

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

NOT INTENDED AS A BLANKET RELEASE FOR INFORMATION OF SERVICES PROVIDED.