Student Health Center
PO Box 1923 • Niagara University, NY 14109-1923
Phone: 716-286-8390 • Fax: 716-286-8391

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name	Date of Birth ___/___/___	Social Security Number	University ID#
Address: Street / City / state / zip	Phone: (Home)	(Cell)	

The following individual, organization or facility is authorized to release information.

- ❑ Niagara University Health Center, PO Box 1923, Niagara University, NY 14109-1923
- ❑ Other (specify) Name ______________________
  Address ______________________

To the following organization or individual:

- ❑ Niagara University Health Center, PO Box 1923, Niagara University, NY 14109-1923
- ❑ Other (specify) Name ______________________
  Address ______________________
  Name ______________________
  Address ______________________
  Name ______________________
  Address ______________________

Information to be disclosed

- ❑ Immunization Records ______________
- ❑ Laboratory Results date(s) and Test(s)
- ❑ Physical Examiniation ______________
- ❑ X-Ray Reports date(s) and x-ray of:
- ❑ Progress Notes date(s)______________
- ❑ Other diagnotic reports date(s) and study______________
- ❑ Complete Medical Record
- ❑ Emergency Room Report date______________
- ❑ Other______________ ______________
- ❑ Discharge Summary date ______________
- ❑ Current Health Condition (specify condition)______________

Reason for Disclosure:

- ❑ Continued Medical Care
- ❑ Legal
- ❑ Disability Support/Accommodation
- ❑ Counseling Support Services
- ❑ Registration at another college/university
- ❑ Work requirement
- ❑ Parent/Guardian Notification of illness/injury or current health status
- ❑ Niagara University Academic Dean for missed class
- ❑ Niagara University Faculty for missed class
- ❑ Niagara University Athletic Trainer for participation in sports
- ❑ Health Insurance Company for claims payment
- ❑ Other (specify):

This authorization will automatically expire in 180 days (6 mnoths) unless the undersigned specifies another expiration date, event or condition as noted:

____

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and, if so, may no longer be protected by Provider's privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

Signature of patient or legal representative______________________ Date ______________

If signed by legal representative, relationship to patient:______________________