NIAGARA UNIVERSITY

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NAME OF STUDENT **DATE OF BIRTH (MM/DD/YYYY)** **COLLEGE ID #**

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

- ☐ Niagara University Health Services, PO Box 1923, Niagara University, NY 14109-1923
- ☐ Other (specify) Name: _____
  Address: _____

To the following organization or individual:

- ☐ Niagara University Health Service, PO Box 1923, Niagara University, NY 14109-1923
- ☐ Other (specify) Name: _____
  Address: _____
  Name: _____
  Address: _____

Information to be disclosed:

- ☐ Immunization Records
- ☐ Physical Examination
- ☐ Progress Notes date(s): _____
- ☐ Complete Medical Record
- ☐ Other: _____
- ☐ Laboratory Results date(s) and Test(s)
- ☐ X-Ray Reports date(s) and X-ray of: _____
- ☐ Other Diagnostic Reports date(s):_____
- ☐ Emergency Room Report date:_____
- ☐ Discharge Summary date:_____

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 months) 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 acted 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 patient:_____