CONSENT TO RELEASE OR OBTAIN MEDICAL INFORMATION

Student Health Services, University at Buffalo
4350 Maple Road, Amherst, NY 14226
Phone: (716) 829-3316 Fax: (716) 829-2564

Patient Name: _____ Date of Birth: _____

Telephone (with area code): _____ UB Person Number: _____

1. I hereby request and authorize UB Student Health Services to: *(circle choice below)*

Release Information TO OR **Obtain Information FROM**

2. Name: _____

Street Address: _____
City, State & Postal Code: _____

Telephone (with area code): _____ Fax Number (with area code): _____

3. The following medical information may be released: *(check only one)*

- ❑ I consent to the release of **immunization records** which may include tuberculosis test results including any related laboratory and/or radiology reports.
- ❑ I consent to the release of **all medical records** including immunization records, as well as information concerning alcohol and/or drug abuse, sexually transmitted infection testing including HIV and/or mental health issues.
- ❑ I consent to the release of **medical records** with the following exceptions: (Specifically describe the information you **DO NOT** wish to have released) _____
- ❑ I consent to the release of **medical records** relating only to the following treatment or condition: _____
  _____
- ❑ I consent to the release of **medical records** only from this time period: _____ to _____
  Date Date

4. *This authorization will automatically expire within one year of the date of signature.* I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.
   I consent to the release of medical information to the extent stated above:

_____ _____
***Handwritten* or Digital Signature of Patient/Legal Representative or Guardian** **Date**

_____
If Legal Representative or Guardian has signed above, print name and relationship to the patient.

5. Special Instructions: _____

Please allow two weeks upon receipt of the form for processing.

OFFICIAL USE ONLY

Date received: _____ **Completed by:** _____ **Date Completed:** _____ **Delivery Method: Faxed Mailed In person**