

**CANISIUS COLLEGE STUDENT HEALTH CENTER**  
 2001 Main Street, Buffalo, NY 14208  
 Phone: (716) 888-2610 Fax: (716) 888-3217

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Name _____	Date of Birth _____ / ____ / ____	Social Security Number _____ - ____ - ____	College ID# _____
Address: Street, City, State, Zip Code _____	Phone: Home _____	Cell _____	

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

- Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208
- Other (specify) Name: \_\_\_\_\_
- Address: \_\_\_\_\_

The information may be disclosed to and used by the following organization or individual:

- Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208
- Other (Specify) Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- Name: \_\_\_\_\_
- Address: \_\_\_\_\_

**Information to be disclosed**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Immunization Records</li> <li><input type="checkbox"/> Physical Examination</li> <li><input type="checkbox"/> Progress Notes date(s) _____</li> <li><input type="checkbox"/> Complete Medical record</li> <li><input type="checkbox"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Laboratory Results date(s) and test(s) _____</li> <li><input type="checkbox"/> X-ray Reports date(s) and x-ray of: _____</li> <li><input type="checkbox"/> Other diagnostic reports date(s) and study _____</li> <li><input type="checkbox"/> Emergency room report date _____</li> <li><input type="checkbox"/> Discharge Summary date _____</li> <li><input type="checkbox"/> Current health condition (specify condition) _____</li> </ul> |
|---|---|

**Reason for Disclosure:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Continued Medical Care</li> <li><input type="checkbox"/> Legal</li> <li><input type="checkbox"/> Disability Support/Accommodation</li> <li><input type="checkbox"/> Counseling Support Services</li> <li><input type="checkbox"/> Registration at another college/university</li> <li><input type="checkbox"/> Work requirement</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Parent/Guardian Notification of illness/injury or current health status</li> <li><input type="checkbox"/> Canisius College Academic Dean for missed class</li> <li><input type="checkbox"/> Canisius College Faculty for missed class</li> <li><input type="checkbox"/> Canisius College Athletic Trainer for participation in sports</li> <li><input type="checkbox"/> Health Insurance Company for claims payment</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul> |
|--|---|

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 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: \_\_\_\_\_