College Health Service

Authorization for Disclosure

1. I, _____ , hereby authorize Hudson Valley Community
   please print your name
   College to release the following (check all that apply):
   - ☐ Immunization Records
   - ☐ Physical Exam Record
   - ☐ Treatment Records, including laboratory information
   - ☐ Other Information (please list) _____

   concerning the following condition and/or related date of service:

   _____

2. Name, address and fax number of person or organization to whom this information is to be released:

   _____

   _____

   _____

3. Purpose of Disclosure: _____

4. I understand this is consent for a <u>one time disclosure only</u> and that the requested information will be released within five (5) working days of the request. I further understand that I may revoke this consent anytime before the disclosure has occurred.

   I waive any and all claims against Hudson Valley Community College and the College Health Service in connection with the communication and disclosure of such information as requested.

5. Signed at Hudson Valley Community College this _____ day of _____ 20 _____

   Signature _____

   HVCC ID or DOB _____

   Address _____

FOR OFFICE USE ONLY

Witness: _____ Date: _____

Released by:_____ Date: _____ Form: letter fax e-mail other_____

Please return this form to:
Hudson Valley Community College
College Health Service
80 Vandenburgh Avenue
Troy, NY 12180

CHS006-12