WICKER WELLNESS CENTER
807 Union St., Schenectady, NY 12308
Phone: 518-388-6120 Fax: 518-388-6147
uchealthcenter@union.edu

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Student Patient Name (First, Middle, Last): _____ Date of Birth: _____

Student Patient Address, Contact #, Email: _____

INFORMATION TO BE RELEASED: □ TO □ FROM

Name: **Wicker Wellness Center Staff / Collaborating Physician**
Please scan requested records and email to uchealthcenter@union.edu

INFORMATION TO BE RELEASED: □ TO □ FROM

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____Fax Number: _____

PLEASE RELEASE THE FOLLOWING INFORMATION (check all that apply)
(Dates: From_____ To _____)

○ Immunizations	○ History & physical	○ Prescriptions
○ PCP office notes	○ ER report	○ Urgent Care report
○ Specialty office notes	○ Operative reports	○ Discharge summary
○ Lab results	○ Radiology reports & images	○ Entire record
○ Billing information	○ Psychotropic medications	

IMPORTANT NOTE: Checking "Entire Record" above will not approve the release of the following special categories of information. To authorize the release of any of the following special categories of information, please check and initial below:

☐ Mental Health Testing/ Treatment ☐ Alcohol/Drug Treatment/Testing ☐ Genetic Testing Information ☐ HIV/AIDS Related Information ☐ Psychotropic Medication Records

PURPOSE OF RELEASE (check all that apply):

_____ Insurance _____ School Disability
_____ Continuing Health Care _____Legal
_____ Other (specify) _____

ADDITIONAL TYPE OF DISCLOSURE:
☐ By checking this box, I authorize verbal communication (i.e., telephone calls) between the parties listed above.

EXPIRATION DATE:
This authorization will remain in effect for one (1) year from the date of signature unless you specify otherwise.

☐ Other expiration date _____

RIGHT TO REVOKE:
I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it.

SIGNATURE:

By signing below, I authorize release of my health records in accordance with the specifications listed above.

Student Patient Name (PRINT): _____ Date: _____

Student Patient Signature: _____Date: _____

Witness Name (PRINT): _____ Date: _____

Witness Signature: _____ Date:_____