Consent to Release or Obtain Medical Information

Allow two weeks, upon receipt, for processing. This authorization will automatically expire within one year from 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. Please note this form requires a ***hand-written*** signature.

Patient Information

Patient Name:

Date of Birth:

Telephone (with area code):

UB Person Number:

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

- Release Information to
- Obtain Information from

Recipient Information

Name of Person or Facility

Address (full mailing address):

Telephone (with area code):

Fax Number (with area code):

Nature of Consent

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 condition:

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Affirmation of Consent

I consent to the release of medical information to the extent stated above:

Hand-Written Signature of Patient/Legal Representative or Guardian

Date

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

Special Instructions:

Official Use Only

Date received:

Completed by:

Date Completed:

Delivery Method:

Faxed

Mailed

In person

Contact Information

Student Health Services

University at Buffalo

Michael Hall

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Phone: (716) 829-3316

Fax: (716) 829-2564