AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By **initialing** the spaces below, I, _____ DOB _____ hereby authorize,

LE MOYNE COLLEGE, Wellness Center for Health and Counseling to:

_____ release information to _____ obtain information from: _____ exchange information ***verbally*** with:

Name: _____ Phone: _____

Street: _____ Fax: _____

City: _____ State: _____ Zip: _____

The information will be used on my behalf for the following purpose(s): _____

_____

By **initialing** the spaces below, I specifically authorize the release of the following medical records, *if such records exist:*

____ **Any or all Medical Records** needed for continuity of care

____ Clinic office chart notes
____ Physical therapy records
____ Emergency and Urgent care records
____ Laboratory reports
____ Pathology reports
____ Medication records
____ Immunization records

____ **Mental Health** information (*must be initialed to be included in other documents*)

____ **Drug/Alcohol** diagnosis, treatment or referral information (*Federal Regulations, 42CRF Part 2, requires a description of how much and what kind of information is to be disclosed).* _____

_____

____ **Other** _____

Le Moyne College Wellness Center for Health and Counseling
Seton and Romero Hall / 1419 Salt Springs Road / Syracuse, NY 13214-1399
Health Fax: 315-445-4714 OR Counseling Fax: 315-445-4592

Attn: _____
(be specific)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or upon your separation from the College, whichever is later.

_____ _____
Date Signature of patient or client

_____ _____
Date Signature of clinician approving release of records