Department of Student Wellness
Authorization for Release of Confidential Health/Medical Information Form

I AUTHORIZE THE FOLLOWING CONFIDENTIAL HEALTH/MEDICAL INFORMATION TO BE RELEASED FROM THE TREATMENT RECORDS OF:

Student Name: __________________________ Date of Birth: __________________________________

Email: __________________________________ Phone Number (Domestic Only): ___________________

X-number: ________________________________ Date: ____/____/_____

Start Year Attended St. John's University: ___________

End Year Attended St. John's University: ____________

Office Releasing Information:

☐ Student Health Services	☐ Center for Counseling and Consultation
☐ Office of Disability	☐ SOAR: Sexual Violence Outreach, Awareness, & Response
☐ Wellness Education and Prevention	☐ Other: ________________________________

Person Receiving this information:

Name: __________________________________ Phone Number: ___________________________________

Address: ____________________________City:______________ State:__________ Zip Code: _________

Email: ___________________________________

Purpose of Disclosure:

☐ Coordination of care	☐ Legal Reasons
☐ Medical/mental health treatment	☐ Personal
☐ Insurance	☐ Other (Please specify:___________________________)

The format in which you would like the disclosure to occur:

☐ Mail ☐ Verbal ☐Electronic ☐In Person, I will pick up

Description of information to be released from treatment record (use check box below):

☐ Immunization Records

☐ Summary of treatment and evaluation

☐ Record from (insert date) _____________________ to (insert date) ____________________

☐ Entire record

☐ Other (please specify) ____

I, or my authorized representative, hereby authorize St. John's University Department of Student Wellness to share my confidential health/medical information. I understand that:

1. Information relating to ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT, and/or CONFIDENTIAL HIV-RELATED INFORMATION will not be shared unless I specifically give permission by placing my initials in the appropriate space(s) below:

Initials	**Type of Record**
	Alcohol or Drug Treatment
	Mental Health Treatment
	HIV-Related information (If yes, please complete an official NYSDOH HIV release form)

2. Except for HIV information, information that is shared because of this authorization may be shared again by the recipient and no longer protected by law. Unless permitted by law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the use or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450.

3. I can revoke this authorization at any time by providing a written notice to the St. John's University Department of Student Wellness. This revocation will be effective except to the extent St. John's University Student Health Services has already relied upon this authorization, and to the extent St. John's University is required or permitted by law to disclose your confidential health/medical information.

I have read and fully understand the above statements and consent to the disclosure of my treatment record for the purpose and to the extent stated above.

Print Name____

Signature of Patient or Personal Representative_________________________________ Date_________

Description of Representative's authority____

Parent/guardian signature (if under 18 years of age)_____________________________ Date_________