MARIST | HEALTH SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please be sure to thoroughly complete information below and print clearly.

I authorize the following protected health information to be released from the health record of:

Last Name:_____ First Name:_____

DOB:_____ CWID:_____ Cell Phone #:_____

RELEASE RECORDS

☐ FROM or ☐ TO ⟷ ☐ FROM or ☐ TO

Health Services
Marist College
3399 North Road - SC Room 352
Poughkeepsie, NY 12601-1387
Phone: (845) 575-3270
Fax: (845) 575-3275
Health.Services@Marist.edu

Name/Organization:_____

Street Address:_____

City/ST/Zip:_____

Phone:_____

Fax:_____

☐ Mail records ☐ Fax records ☐ Discuss verbally ☐ Student pick up

☐ **Info release is:** ☐ One time ☐ Ongoing until:_____

*Each release requires individual review by a clinician. Please allow up to 30 days to fulfill your request.

If your request is time sensitive, please indicate date needed:_____

Purpose of the disclosure:

☐ Further health care/coordination of services ☐ Insurance documentation ☐ Personal use

☐ Legal investigation ☐ Academic accommodation ☐ Other

Treatment Date(s) _____ Information to be disclosed: ☐ Clinical Notes ☐ Lab Reports

☐ Radiology Reports ☐ Other:_____

Initial if you wish to include the following: _____ Alcohol/Drug treatment _____ Mental Health Related information

_____ HIV-Related Information _____ Other:_____

I understand that:

- I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
- Unless otherwise revoked, this authorization will expire on date _____. If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.

I have read and understand the information in this authorization form.

Signature:_____ Date:_____

FOR OFFICE USE ONLY

Director's Signature:_____

Outgoing records were ☐ Discussed ☐ Faxed ☐ Mailed

☐ Picked up By Print Name:_____ Signature:_____

Incoming records were ☐ Discussed ☐ Faxed ☐ Mailed ☐ Delivered by Initials:_____

As confirmed by Health Center Staff: Initials:_____ Date:_____

Rev 2020