Vassar College Health Services
Authorization for Release of Student Health Information and/or Sensitive Student Health Information

Student Name: _____ DOB: _____

Student Non-Campus Address: _____

I. My signature below indicates that I authorize the release of **non-sensitive STUDENT HEALTH INFORMATION** (not including information related to ALCOHOL and/or DRUG TREATMENT, MENTAL HEALTH TREATMENT, and/or CONFIDENTIAL HIV/AIDS-RELATED INFORMATION) as follows:

BY: Health Services, Vassar College, 124 Raymond Ave., Poughkeepsie, NY 12604

☐ All written records ** _____(Initials)
EXCEPT: _____

☐ By oral communication** _____ (Initials)

EXCEPT: _____

TO: _____(Name of Receiving Individual and/or Entity)

Relationship to Patient: _____

Address: _____

Fax: _____ Tel: _____

II. My initials and signature below indicate that I authorize the release* of **SENSITIVE HEALTH INFORMATION** (ALCOHOL and/or DRUG TREATMENT, MENTAL HEALTH TREATMENT, and/or CONFIDENTIAL HIV/AIDS-RELATED INFORMATION) to the receiving party indicated above, as follows:

For the following to be included, indicate the specific information to be disclosed and INITIAL at right	Information to be disclosed (write either ALL RECORDS or specify which ones)	Information to be disclosed VERBALLY ONLY? (Yes/No)	Initials
Records from alcohol/drug treatment programs*			
Clinical records from mental health programs*			
HIV-AIDS related information*			

***The release of ANY sensitive health information pursuant to this authorization MUST be accompanied by a Notice of Prohibition on Redisclosure, in accordance with federal and New York law and/or Vassar College policy.**

Effective Period: Unless I revoke this authorization, the specific information above may be disclosed from the date of my signature below to _____ (date or event).

Right to Revoke: I have the right to revoke this authorization at any time in writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on it.

Voluntary Signature: Signing this authorization is voluntary. I understand that my receipt of health care and/or support services at Vassar College will not be conditional upon my authorization of disclosure, unless Health Services is providing care solely for the purpose of communicating health information to a third party.

All items on this form have been complete, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____

Signature of Student or Legally Authorized Representative **Date**

Representative's authority to sign on behalf of Student: _____

Name of Representative: _____

_____ _____

Name and Signature of Witness Date