Southern Connecticut State University
SCSU
Student Health Services

Date:_____

Authorization to Release Health Information

Student Information:

Name: _____ Banner ID: _____ Date of Birth: _____

Phone Number: _____Current Email: _____

***We will communicate the status of this release request by email.**

Release Information to:
If requesting documents to be released to yourself, write "Self"

Agency Name and Agency Address:

_____

_____

CHECK ONE:

☐ Mail to the Agency and Address above ☐ Fax: _____☐ I will pick up at Student Health Services on _____

***For privacy reasons, we do not email personal health information.**

The Purpose of the Authorization is indicated below. (Please check all that apply)

☐ Further Medical Care
☐ Immunization Records
☐ Other (Specify
☐ Changing physician
☐ Personal
☐ Legal Investigation or Action

I authorize the release of the following protected health information

☐ Entire record
☐ Laboratory Reports
☐ X-Ray Reports
☐ Other_____
☐ Immunizations
☐ Treatment or Tests
☐ Prescriptions

This authorization is needed for the period starting_____and ending on _____. I understand that if I do not specify an expiration date, the authorization will expire (6) months from the date on which it was signed. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information describe above.

_____ _____
Signature Date

_____ _____
Name Printed Date

Email this completed form to Healthservices@southernct.edu. Please allow 5 business days for this request to be completed.
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