SUNY Poly Wellness Center
100 Seymour Road
Utica, NY 13502
Phone: 315.792.7172
Fax: 315.792.7371

SUNY POLYTECHNIC INSTITUTE

Student name: ______________________________
SUNY Poly ID #: U______________________________
Date of Birth: ______________________________

I authorize the use or disclosure of my individual identifiable protected health information by any current employee of the SUNY Poly Wellness Center, or any other person/facility listed below to disclose my protected health information as described on this form to the person(s)/organization listed below. I retain the right to revoke this authorization at any time.

Authorization for SUNY Poly Wellness Center to:

Release medical records **TO** a person/organization

- I authorize SUNY Poly to: Fax Send/Mail Provide me Discuss
- A copy of my: (Check all that apply)
  - Immunization Record
  - Physical Exam Record
  - Accident/Injury Report
  - Medical Record (Specify): ______________________
  - Other (specify):______________________________
- To: Name(s)______________________________
  Address______________________________
  Phone Number______________________________
  Fax Number (if applicable)______________________________

--- ***OR*** ---

Obtain medical information **FROM** a person/organization

- I authorize:______________________________
  Name of healthcare professional/organization
  ____
  Address
  ____
  Phone Number Fax Number (if applicable)
- To: Release medical information to health care professionals at the SUNY Poly Wellness Center by phone, fax, email, or as deemed necessary to provide proper medical care to me

  Release to SUNY Poly a copy of my: (Check all that apply)
  - Immunization Record
  - Physical Exam Record
  - Accident/Injury Report
  - Medical Record (Specify): ______________________________
  - Other (Specify):______________________________

Student Signature:______________________________Date:__________________

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