Health Services
MONROE COMMUNITY COLLEGE

Authorization for Release of Medical Information

Student's Name: _____ Date of Birth: _____
MCC ID #:_____ Patient's phone #: _____
Address: _____
City/State/Zip Code: _____
Date of Request: _____ Date Needed: _____

I Authorize MCC Health Services To (Circle One): Release Information To or Obtain Information From:
Name of Provider or Facility: _____
Address:_____
City: _____ State: _____ Zip Code: _____
Phone #:_____ Fax # (include area code):_____

Purpose of This Request:
(Check one): Healthcare ___ Insurance Coverage ____Transfer of Care____ Other: _____

Type Of Records Requested: (Check as appropriate)

- Immunization History_____ Vaccines Given by HS only_____ Include records submitted to HS_____
- All medical records related to a specific illness/injury (include dates):_____
- Treatment summary (includes history/physical, lab tests & x-ray reports, operative reports, pathology)_____
- Other Specific information: _____
  _____

Authorization Valid For: (Check one.)
_____This request only.
_____ One year from the date of this authorization **or until:** _____.
_____ Records of the treatment received on or prior to the date of this authorization.
_____This request *and* for records of any *future* treatment of the type described above until _____ .

I Understand That:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided above, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is *not* a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires a separate authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative: _____ **Date:** _____

Relationship to Patient (if requester is not the patient):_____

MCC Health Services
1000 East Henrietta Rd, 3-165
Rochester, NY 14623-5780
Phone: (585) 292-2018 Fax: (585) 292-3856
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