

Employee/Student Health
4th Floor Jacobsen Hall
750 East Adams Street
Syracuse, New York 13210



Telephone: (315) 464-4260/ 464-5470
Fax #: (315) 464-5471
www.upstate.edu

AUTHORIZATION FOR RELEASE MEDICAL RECORDS

Date: _____

Name: _____ S.S.#: _____

D.O.B.: _____ Home Phone: () _____

(Circle One) Employee, Volunteer, Student Class: _____ Program: _____

If not active, (Termination Date: _____)

I, _____ hereby authorize SUNY UPSTATE MEDICAL UNIVERSITY EMPLOYEE/STUDENT HEALTH SERVICE to copy and release the following medical information on myself:

- | | |
|---|---|
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Annual Health Assessment |
| <input type="checkbox"/> Tuberculosis Test(s) | <input type="checkbox"/> Lab Work |
| <input type="checkbox"/> Other: _____ | |

HIV information cannot be released with this from.

I am requesting this information for the purpose of: _____

Please allow up to two (2) weeks for processing.

Released information (check one)

- Will be picked up at Employee/Student Health
 Fax to: _____ Fax # _____
(Facility)

Written authorization is not valid for more than one (1) year, but may be revoked in writing at any time. This copy has been provided to you free of charge. We suggest you make extra copies.

Employee/Student Signature _____ Witness _____

Date Given/Faxed: _____ Initials: _____

Colleges of: Medicine • Graduate Studies • Health Professions • Nursing • University Hospital

Improving the health of the communities we serve through education, biomedical research, and health care