UPSTATE
MEDICAL UNIVERSITY

EMPLOYEE/STUDENT HEALTH DOWNTOWN CAMPUS
4th Floor, Jacobsen Hall
750 East Adams Street • Syracuse, NY 13210
Phone (315)464-4260
Fax (315)464-5471
Monday - Friday 7:30 am - 5:00 pm
Email: ESHealth@upstate.edu (Subject: Records Request)

EMPLOYEE HEALTH COMMUNITY CAMPUS
4900 Broad Road
Syracuse, NY 13215
Phone (315)492-5624
Fax (315)492-5117
Monday – Friday 7:30 am – 4:00 pm

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____ Upstate ID#: _____

Name: _____ Last four digits of S.S. #: _____

Date of birth: _____ Phone #: _____

(Circle One) Employee Volunteer Student ▶ If not active, provide separation date: _____

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

_____ Annual Health Assessment/ TB Test _____ Lab Work/ Titers/Immunization records

_____ Physical Exam Statement _____ Other (please specify): _____

❋ HIV information cannot be released with this form ❋

Choose **ONE** method of delivery for released information (**allow up to 10 business days to process request**):

_____ I will pick this up at the Employee/Student Health Office (we will call you when information is ready to be picked up).

_____ Fax to: (_____)_____ATTN:_____

_____Email to: (**see note below**)_____

(PLEASE PRINT CLEARLY)

NOTE: all scanned records to any email account other than GroupWise must be encrypted for security purposes. If the email address you provide is an external address (e.g., gmail, yahoo, etc.), the information you receive will be encrypted. To open the email, you must follow the directions in the registration process.

Your signature (required) _____

This authorization expires upon release of requested information.
These copies are provided to you free of charge. We suggest you make extra copies for your records.

OFFICE USE ONLY
Date Completed: _____ Employee initials: _____