UPSTATE
MEDICAL UNIVERSITY

EMPLOYEE/STUDENT HEALTH
750 East Adams Street
Syracuse, NY 13210
Phone: 315-464-4260
Fax: 315-464-5471

Student Authorization for Release of Medical Information

❋ ***HIV-related information cannot be released with this form***

Person whose information will be released:

Name: ____ ID #: ____________

Phone number: ______________________________ DOB:____________________

Program: __________________________________ Year of graduation:_________

Local Address: ____

This form is to be used for medical information needed to satisfy health requirements in outside facilities pursuant to degree-related clinical activities (including documentation of physical examinations, annual health assessments, immunizations, titers, and tuberculosis surveillance).

Release of information is authorized from matriculation through graduation or termination of academic pursuits.

I authorize disclosure of my medical information as described above. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

Signature: _______________________________________ Date: _____________

Print Name: ______________________________________