Sarah Lawrence College
Health & Wellness Center
1 Mead Way, Bronxville, NY 10708

Phone (914) 395-2350
Fax (914) 395-2640

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS/INFORMATION

Sarah Lawrence College Health & Wellness Center and many other organization and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Name: ____ Student ID #: _______________________DOB: ____________

Email: __________________________Phone: ___________________________Last date attended SLC:____________

I HEREBY AUTHORIZE (name of person or facility which has information):

Name/Facility __________________________________

Address_______________________________________

____

Phone ____

Fax ____

☐ TO RELEASE RECORDS TO:
☐ TO PROVIDE INFORMATION TO:
☐ TO RECEIVE INFORMATION FROM:

Name/Facility __________________________________

Address_______________________________________

____

Phone ____

Fax ____

Type of Disclosure *(check all boxes that apply)*: ☐ Written ☐ Verbal Information/Communication

☐Other (please specify): ____

These records are for services provided on the following date(s): ____

Please specify the records you authorize to be released:*

- ☐ Mental Health
- ☐ Treatment Summary
- ☐ Compliance with Treatment Plan
- ☐ Medical
- ☐ Laboratory / Radiology Reports
- ☐ Immunizations/Vaccinations
- ☐ I specifically authorize the release of HIV/AIDS related records
- ☐ Other (specify) ____

*Note: If these records contain any information from previous providers or information about drug/alcohol use or STD, you are hereby authorizing disclosure of this information

Purpose: ☐Personal Records ☐Continuity of Care

☐ Other (specify) ____

Unless otherwise revoked in writing, this authorization expires: _______________ (insert applicable date or event). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

____ ____
Print Name Signature

____
Date

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REQUESTING YOUR MEDICAL RECORD

When requesting a copy of your medical record from Sarah Lawrence College Health & Wellness, please submit the signed "Authorization for Release of Health Records/Information" by fax (914-395-2640), mail or hand delivery.

There is no charge for records requested for continuation of care purposes that are sent directly to your provider.

There is a 0.75 cents per page fee for a request of your medical or mental health record that is not sent directly to your provider.
Please submit appropriate fee, by check, with the "Authorization for Release of Health Records/Information".

All records will be mailed/faxed within two weeks of request.
Any questions can be directed to Sarah Lawrence College Health & Wellness Center 914-395-2350.