For Appointments Call

Hofstra Health & Wellness Center

516-463-6745

Republic Hall, North Campus Fax 516-463-5161

AUTHORIZATION FOR CONSENT FOR RELEASE OF HEALTH RECORDS

I, the undersigned, do hereby authorize/consent Hofstra University Health & Wellness Center

Patient Name:_______________________________________ DOB ___/___/___

Hofstra ID# ____________________ Dates of Attendance _____________________

TO:
Physician and/or Facility Representative: ____

Mailing Address: ____

Fax #: _____________________________________ Phone #: _________________________________

The information to be released is limited to the following: (**initial all items for which release is approved**)

_______ Copy of Entire Record (may include communicable disease, HIV virus-related information; drug/alcohol information/mental health information)

________Health Record Notes (may include communicable disease, HIV virus-related information; drug/alcohol information/mental health information)

________Medical Record Form (may include communicable disease, HIV virus-related information; drug/alcohol information/mental health information)

________Immunizations

________Laboratory Reports (may include HIV test results) X-ray reports Specify Dates

________Other

The following information may not be released (please be as specific as possible including approximate dates treatment was provided): ____

Signature: ____ Date: _____/_____/_____

For Office Use Only: Identity Verification

Photo ID: Student ID: ____ Driver's License: ____ Other: ________________________________

REQUESTS FOR RELEASE OF MEDICAL RECORDS BY MAIL OR FAX MUST CONTAIN A NOTARIZED SIGNATURE____

Notary Signature