ALFRED STATE COLLEGE
STATE UNIVERSITY OF NEW YORK

10 Upper College Dr. TA Parish Hall, Alfred NY 14802 –Ph. 607-587-4200

Immunization Release of Information

Name: _____ Date of Birth: _____

ID #: _____ Date last attended: _____

I hereby authorize (select an option below)

☐ Alfred State Health & Wellness Services

☐ Name: _____
Agency: _____
Phone: _____

to release / disclose information to the following individuals and / or agencies to ensure continuity of care:

☐ Alfred State Health & Wellness Services OR

☐ Name: _____
Agency: _____
Phone: _____

Information to be released:

_____ Immunizations

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R part 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that it will automatically expire after 90 days from the date of the signature unless otherwise specified.

Expiration date: _____

I understand that generally Alfred State may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature (client): _____ Date: _____

Signature (witness):_____ Date: _____

Signature (parent / legal guardian ***If under 18***): _____ Date: _____