



AUTHORIZATION FOR CONSENT FOR RELEASE OF HEALTH RECORDS

I, the undersigned, do hereby authorize and consent Hofstra University Student Health Services to release my health information.

Name	Date of Birth		
Hofstra ID Number		Telephone	
Address		Attendance Start Date	
		Attendance End Date	
		Check if currently enrolled	

Person or entity to whom your health information will be released:

TO ME, FOR MY OWN PERSONAL USE

REASON FOR REQUEST

TO ANOTHER ENTITY (Please Describe):

Please indicate how you wish to have the records provided:

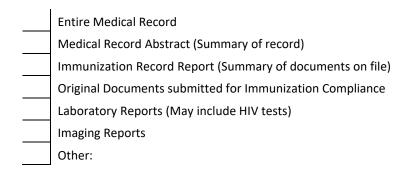
Selection	Manner	Form or Format	Delivery Details
	Postal Mail	Paper Copy	Mailing Address
	Pick up at facility	Paper Copy	Must present ID to pick up records
	Digital Delivery	Secure message on patient portal	Via Medicat
	Fax	N/A	Fax Number:
	Electronic Mail	Sent as an unencrypted email SHS reserves the right to limit records sent via E-Mail. Typically, only immunization records are sent via e- mail.	Initial below to acknowledge your understanding that email is unencrypted, and others may be able to access the information and read it as it is transmitted over the internet.

PLEASE COMPLETE BOTH PAGES





Please check all items for which release is approved. Note that your health record may include communicable disease, HIV, drug, alcohol or mental health information. Your submittal of this form indicates understanding of this information and consent to release these records.



The following information may **NOT** be released:

Print Name	
Date Submitted	
Relationship (If other than patient)	
Signature	

PLEASE COMPLETE BOTH PAGES

For Office Use Only							
Identification Verified:	Hofstra ID	Driver's License	Passport	Initials			
Initial Request Review:							
	Signature		Date				
Approval for Release:							
	Signature			2			
Records Released (Initial)		Form Filed (Initial)					