Alfred University Wellness Center
1 Saxon Drive, Alfred, NY 14802
607-871-2300, 607-871-2400 (office)/ 607-871-2631 (fax)

Consent for Release of Confidential Information

Name: ____________________________________ DOB: ______________

Other Names Used: __________________________

☐ Current Student ☐ Not Current Student (last year of attendance ____)

I, the undersigned, hereby authorize the Wellness Center at Alfred University to disclose/obtain the following information with the agencies or professionals below (please check and initial any that apply):

☐ Medical Progress Notes __
☐ Psychological/Counseling Progress Notes __
☐ Health History/Physical Exam __
☐ Psychiatric Evaluation __
☐ Psychiatric Progress Notes __
☐ Alcohol &/or Other Drug Treatment __
☐ STI Testing/Results __
☐ Laboratory Reports __
☐ Immunizations __
☐ Social History __
☐ Educational History __
☐ HIV/AIDS __
☐ Other Information (please specify) ______________________________________

Purpose of Disclosure:

____

____

Expiration Date (expiration occurs automatically one year from date of signature): __________________

____
Agency/Organization/Provider Name

____
Address

____
Phone/Fax

I understand that this authorization applies to the individual(s) listed above and I may revoke this authorization at any time by notifying my Wellness Center provider or the Director. If I revoke authorization, I understand that it will not have any effect on any action/communication that was done prior to the revocation. I acknowledge that this authorization is given voluntarily. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment. The Wellness Center employees and contracted designees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

______________________________ ______________________________ ________
Print Name Signature Date

______________________________ ________
Witness Signature Date