J #_____

Jefferson Community College Health Services

1220 Coffeen Street, Watertown, NY 13601

Telephone 315-786-2376 Fax 315-786-2382

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

1. **I AUTHORIZE THE RELEASE OF PHI TO BE RELEASED FROM MY HEALTH RECORD**

   Last Name (include former name if applicable) _____

   First Name_____ Date of Birth _____

   Street Address _____

   City, State, Zip Code _____

   Current Telephone Number _____

2. **RELEASE RECORDS TO**

   Myself: ☐

   ☐ Mail to the above address

   ☐ Mail to _____

   ☐ Fax to Place

   _____
   Street Address

   _____
   City, State, Zip Code

   _____
   Fax

3. **INFORMATION TO BE RELEASED**

   ☐ Immunization Information ☐ Health Notes ☐ Physical Exam

   ☐ Sports

   ☐ Health Professions

4. **THE SIGNING OF THIS FORM IS VOLUNTARY AND UNLESS OTHERWISE REVOKED WILL EXPIRE ON _____ OR IF NO SPECIFIED EXPIRATION DATE THE AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM DATE OF MY SIGNATURE**

5. **I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON THIS AUTHORIZATION**

NOTE: Federal confidentiality rules (42 CFR part 2) protect records pertaining to alcohol, drug, or mental health information. These federal rules prohibit the Receiving facility from making further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR part 2.

I have read and fully understand the above statements and consent to the disclosure of my health information.

Signature _____ Today's date _____

JCC Health Services Staff Only

Date released _____

Released by _____

For fax of records:

- Confirmation received ☐ Yes Date and Time _____