

D'YOUVILLE UNIVERSITY

AUTHORIZATION TO RELEASE OR OBTAIN STUDENT HEALTH INFORMATION

Purpose

Pursuant to the Family Educational Rights and Privacy Act, D'Youville University is required to protect the privacy and confidentiality of student records, including certain health information maintained by the University. Accordingly, the University may not disclose such records to third parties without the student's prior written consent, except as otherwise permitted or required by law.

This authorization form enables the student to provide informed, written consent for the release or receipt of specified health information. By completing this form, the student designates the information to be disclosed, the recipient(s), and the purpose of the disclosure. This process ensures that any release of information is conducted in compliance with applicable federal regulations and institutional policies.

Instructions

Complete each blank field, sign and return this form to healthcompliance@dyu.edu.

Student Information

Name: _____

Date of Birth: _____

DYU Student ID: _____

Phone: _____

Authorization

- Release my health information TO
- Obtain health information FROM

Recipient / Sender Information

Name: _____

Organization: _____

Mailing Address: _____

Phone: _____

Email Address: _____

Purpose of Disclosure

- Continuity of care
- Insurance/billing
- Academic accommodation
- Personal use
- Other: _____

Information to be Disclosed

General Health Information

- Immunization records (including TB testing)
- General medical records (e.g physical exams, visit summaries, vital signs, allergy information, non-psychiatric medication lists, basic lab results, etc.)

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Sensitive Health Information

Sensitive categories listed below require separate, explicit consent and will not be disclosed unless specifically authorized by the student.

Mental health records

By checking this box I specifically authorize the disclosure of mental health records, including clinical notes, evaluations, and treatment information, maintained by D'Youville University. I understand these records are protected under New York Mental Hygiene Law §33.13 and may not be disclosed without my explicit written consent, except as permitted by law.

HIV/AIDS or sexually transmitted infection (STI) information

By checking this box I specifically authorize the disclosure of information related to HIV/AIDS, including HIV test results, diagnosis, treatment, and any related information. I understand that this information is protected under New York Public Health Law Article 27-F, and that:

- *This information may not be disclosed without my specific written consent*
- *I have the right to refuse to authorize disclosure*
- *Redisclosure of this information is prohibited without additional authorization*

Alcohol and/or drug use treatment records

By checking this box I specifically authorize the disclosure of information related to alcohol and/or drug use diagnosis, treatment, or referral. I understand that these records are protected under federal law (42 CFR Part 2) and applicable New York State law, and that:

- *My consent is required for disclosure*
- *I may revoke this consent at any time (except to the extent action has already been taken)*
- *Information disclosed pursuant to this authorization may not be re-disclosed without my additional written consent unless otherwise permitted by law*

Limitations

- Only records related to: _____
- Exclude the following information: _____
- Date range: _____ to _____.

FERPA Acknowledgement & Re-Disclosure Notice

- By checking this box I understand that my health records may be considered education records under FERPA and that once disclosed, they may no longer be protected and could be redisclosed.

Voluntary Authorization

- By checking this box I understand this authorization is voluntary and that refusal will not affect eligibility except where required.

Expiration & Revocation

Expires: _____ (Default one year from date below).

By checking this box I understand that I may revoke this authorization at any time.

Signature

Signature: _____

Date: _____

If representative:

Name: _____

Relationship: _____