

1 Academic Drive Corning, NY 14830 Phone: 607-962-9257

Fax: 607-962-9248

healthoffice @corning-cc.edu

Authorization to Release Medical Information

By signing below I authorize you to release my protected health information, as specified below, to the agency listed on this form. I understand that I may withdraw this authorization at any time and that my information will only be shared as I have requested.

Student Name:	Date of Birth
Address:	
City / State / Zip Code:	
Date of Request:	
I authorize SUNY Corning Community College Health Office to release information to:	I authorize SUNY Corning Community College Health Office to obtain information from:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City / State / Zip Code	City / State / Zip Code
Phone #	Phone #
Fax #	Fax #
□ Type of records requested: ☐ Immunizations only ☐	Health Office visit notes Other:
Authorization Valid For:	Specify date authorization will expire:
Signature of student or representative:	Date:
Relationship to student (if request is made by a paren	nt or legal guardian;