

Health & Wellness Services 2800 Victory Blvd • Bldg 1C, Room 112 Staten Island, NY 10314 Telephone 718.982.3045 Fax 718.982.2966 TTY 718.982.3315

AUTHORIZATION FOR RELEASE OF INFORMATION

ast nai	me First name	Maiden name, if applicable		
	//	Status:	☐ Current student	☐ Former student
ate of	EMPL ID#			Date of exit://
omj	plete section A or B . All requestors to comple	te sectio	n <i>C</i> .	
\boldsymbol{A}	I request CSI Health & Wellness services to take the following action:			
	\square Fax or email a copy of my health information to	me at:		
			Iy fax number or email addr	
	☐ Mail a copy of my health information to me at:	Address		
		City		State Zip Co
	☐ I will pick up a copy of my health information a	t the Heal	th Center (1C-112)	
	☐ Fax or email a copy of my health information to			
		Name of	person or entity	
		Fax numi	ber or email address	
	Note: Verification of picture identification is requi	ired prior	to the release of inf	Formation.
	I request the person or entity listed below to rele			tir & veimess per vices.
	To: College of Staten Island		Telephone: 718.982	2 3045
	Health & Wellness Services		Fax: 718.982.2966	2.5045
	2800 Victory Blvd		Email: healthcenter	@csi.cuny.edu
	Building 1C, Room 112 Staten Island, NY 10314			
C	Specific information for release:			
	☐ Immunization Record ☐ Lab Results		☐ Physical	☐ Medical Record
	☐ Other:			
	Please describe			
	uestion of privacy between the institution, provider, and a authority extends to the furnishing of copies of all or any			er medical record.
				/ /
ignatu	re of requestor			Date ———
reques	stor is not the student:			
	Last name (please print)	1	First name (please print)	Relationship to student
FOR (OFFICE USE ONLY:			
-	received: / / Date processed	۸.	/ /	Photo ID verified by: