



### Verbal Communication Release Form

1. By signing this release, I authorize Cayuga Health at Ithaca College to discuss my health information, in person or by telephone, with Ithaca College representatives and/or services such as CAPS, Residential Life, ICare, etc. I acknowledge that this release is for verbal communication only and does not allow for copies of my medical records to be released:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

2. Information to be discussed may include:

All health information.

Include the following (indicate by initialing):

[ ] Alcohol/Drug Treatment Information

[ ] Mental Health

Limitations: there are limitations on what may be discussed regarding the following medical condition(s): \_\_\_\_\_

3. Purpose of Communication: To facilitate the student's success while attending Ithaca College.

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Cayuga Health at Ithaca College in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cayuga Health at Ithaca College before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

4. Unless otherwise revoked, this authorization will expire when I am no longer enrolled at Ithaca College.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Today's Date: \_\_\_\_\_