Cayuga HEALTH

ITHACA COLLEGE

Student Health Services

Universal 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: If you decline this service please mark below, sign and date**

Name: _____ Date of Birth: ___ /___/____

Address: _____

Phone#: _____

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.

( ) I am declining this service

Student Signature: _____
Student Ithaca College Id#

_____

Today's Date: ___/___/_____

Witness Signature: _____

_____

Today's Date: ___/___/____

CHIC0003