ALFRED STATE
Phone: 607-587-4200
Consent for the Release of
Confidential Information
TWO-WAY
I, _______________________________________________________, hereby authorize Alfred State Health and
Wellness Services to disclose/receive records to/from__________________________________________________________
mail (provide address) or email (provide email) ____________________________________________ the following information:

_____ History   _____Assessment       _____Treatment plan   _____Progress with treatment

_____Immunization record    _____History and physical examination

_____Other (please specify) ______________________________

The purpose of the disclosure authorized in this consent is to: __________________________________________________________

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records,
and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand
that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it,
and that it will automatically expire after 90 days from the date of the signature unless otherwise specified.

I understand that generally Alfred State may not condition my treatment on whether I sign a consent form, but that in
certain limited circumstances I may be denied treatment if I do not sign a consent form.

Date________________________________________________________

Signature of Client                                                                                      Signature of parent, guardian, or authorized
representative (when required)

Signature of Witness                                                                                       Date

I hereby CANCEL my authorization to release the information outlined in this form.

__________________________________________   __________________________________________
Signature of Client                                                                                      Date

Signature of Witness                                                                                       Date

__________________________________________
FOR OFFICIAL USE

DONE BY________________________________________    DATE________________________________________