



1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Last Name _____ First Name _____ Date of birth ____/____/____
Email Address _____ CU ID# _____ Phone # _____
Address _____ City _____ State _____ Zip Code _____

2. RELEASE RECORDS FROM or TO 

Gannett Health Services Health Records Dept.
110 Ho Plaza
Ithaca, NY 14853-3101
Phone: 607/255-4082 Fax: 607/255-0269

RELEASE RECORDS FROM or TO

Name/Organization : _____
Street Address _____
City / State / Zip Code: _____
Phone: _____ Fax _____

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL MEDICAL RECORD

- Rabies Vaccination Rabies Titers
 Hepatitis B Vaccination Hep B Titers
 Other: _____

4. REASON FOR RELEASE OF INFORMATION: Occupational Medicine

5. SIGNATURE OF PATIENT/CLIENT (or representative authorized by law)

- I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.
- Unless otherwise revoked, this authorization will expire on (date or event) end of affiliation with Cornell University.
If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.
- I may revoke this authorization in writing at any time, except to the extent that Gannett Health Services has already relied on this authorization.
I may revoke it by sending a written notice to the H.I.M. Administrator (at the address/fax number above) stating my intent to revoke this authorization.
- I understand that information disclosed under this authorization might be redisclosed by the recipient and may no longer be protected by privacy laws.
- I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.

I have read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above.

▶ Signature _____ ▶ Today's date _____