AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Student's Program of Study: _____

I _____ hereby authorize the Student/Employee
NAME
Health Service of SUNY Downstate Medical Center/University Hospital of Brooklyn to release the following protected health information from my medical record to a program office or an employee/student health service of a hospital or other educational institution for the purpose of health clearance for clinical rotations and educational training:

- Measles, Mumps, Rubella, Varicella immune status and dates of vaccines, including Tetanus/diphtheria booster.
- Hepatitis B immune status (or presence of positive antigen) and dates of vaccine if available.
- Tuberculin testing dates and results.
- Chest x-ray date and result (if tuberculin test is positive).
- A general statement that I am free of any condition which would impair my ability to function in the clinical setting.
- In the event of a health condition, which will require special accommodation or precautions from the site, a brief statement describing the condition and the accommodation needed. *Please note that HIV antibody results, if present in your record, are **not** released. By law, release of HIV information requires a separate specific consent form.*

Without this signed form the Student Health Service (SHS) cannot provide health clearance to clinical sites, and you will be unable to do your clinical rotations and educational training. If you have any questions regarding this release of information, please contact SHS at 270-2018, or come to the SHS office. The signed and dated form must be returned prior to registration to the SHS at Box 33, or bring it to the SHS at 440 Lenox Road, Apartment 1S.

This authorization will be in effect for the duration of your enrollment at SUNY Downstate. You have the right to revoke this authorization at any time. You also have the right to request restrictions on the information provided. However, doing so might restrict your ability to be assigned to a clinical site.

I have read the above statements and am aware of and agree to the sharing of my protected health information.

_____ _____
Signature of Student Date