

**SOUTHERN CONNECTICUT STATE UNIVERSITY  
GRANOFF HEALTH SERVICES  
AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_ DOB \_\_\_\_\_ ID# \_\_\_\_\_  
Authorize Granoff Student Health Services of Southern Connecticut State University  
501 Crescent Street  
New Haven, CT 06515  
Phone 203-392-6300 FAX 203-392-6301

to release copies of my medical records to the following person (s) or agency (list name, address, phone & FAX)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone/ Fax \_\_\_\_\_

The information to be released from my records covers the period from \_\_\_\_\_ to \_\_\_\_\_ and consists of \_\_\_\_\_.

I understand that this information shall remain strictly confidential and shall not be further relayed in any other way to any other person or agency without an additional authorization by me.

By signing this Authorization to Obtain Information, I release the Director of the Health Center, the Health Center Staff, and Southern Connecticut State University and its employees, as well as the person(s) or agency named above, from any liability resulting from the release of this information. Furthermore, I understand that I may withdraw this Authorization at any time prior to the release of the above information. This Authorization, if not withdrawn, will expire on \_\_\_\_\_ or 60 days after the date it is signed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date