Student Support Services
Pharmacy Building B-04
Tel. (718) 488-1044
Fax (718) 834-6045

Consent for Release/Exchange of Information

Name _____ **Social Security Number** _____

I, the undersigned, authorize the professional exchange of medical records and/or testing materials and information between the following:

Student Support Services
1 University Plaza Brooklyn, New York 11201
Long Island University Brooklyn Campus
and:

Name of Agency or Individual: _____

Address: _____

_____

Student's Name (Print): _____
Last First MI.

Address: _____

_____

Student's Signature: _____ Date: _____

I understand that such disclosure is bound by regulations governing the confidentiality of medical/psychological records and any additional disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I also understand that I have the right to cancel my permission to release information at any time before it is released.