ELIZABETHTOWN COLLEGE STUDENT HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information
Name: Last, First, Middle Initial: _____

Street Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Student ID Number: _____ Date of Birth: _____

I authorize Student Health, a unit of Student Wellness at Elizabethtown College, One Alpha Drive, Elizabethtown, PA 17022 (Phone: 717-489-1021, Fax: 717-361-0202)) to:

[ ] Release my information to: [ ] Obtain my information from: [ ] Exchange my information with:

Person or facility to receive/exchange my information
Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

The information to be released is:
[ ] Current Medications
[ ] Medical Records
[ ] Treatment Plan
[ ] Immunization Records
[ ] Diagnosis
[ ] History and Physical Exams
[ ] X-Ray/Imaging Report
[ ] PPD Tuberculin Test
[ ] Lab Tests/Results
[ ] Other: _____

Limitations of this Authorization (if nothing is indicated, no limitations)**:** _____

The purpose of this disclosure is for:
[ ] Coordination of Care/Treatment
[ ] Administrative and/or Academic Coordination
[ ] Other: _____

Type of Disclosure Requested (mark all that apply)**:**
[ ] Oral
[ ] Electronic
[ ] Letter/Mail

This authorization is given voluntarily with my full realization that the information is confidential material. I understand that I may cancel this authorization at any time by submitting a written request to Student Health, except where a disclosure has already been made in reliance on my prior authorization. A copy of this authorization shall be considered as valid as the original.

Expiration of Authorization: Unless otherwise canceled, this Authorization expires on _____
If no date is indicated, the Authorization will expire 12 months after the date of your signature.

Client Signature: _____Date: _____

Witness Signature: _____ Date: _____

Revised 7/1/14 BL