



Student Health Services
Heinz Hall – Lower Level
(215) 572-2966 Fax (215) 881-8787

Authorization of Release of Confidential Health Information Disclosure of Protected Health Information

Name _____ DOB

FR SO JR SR GRAD PROGRAM _____ Year graduated

I HEREBY AUTHORIZE THE RELEASE OF HEALTH INFORMATION:
(Please circle *TO* or *FROM*)

TO / FROM Arcadia University, Student Health Services ATTN: RELEASE OF INFORMATION

TO / FROM NAME: _____

Maiden Name: _____

ADDRESS: CITY STATE, ZIP _____

PHONE: () _____ FAX #: () _____

Please indicate information and dates to be released:

Office visit notes _____ Lab results _____

x-ray results or film _____ other _____

Diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease (AIDS/HIV) are NOT Included in a general release. Please indicate information and specify dates to be released and initial.

_____ Mental Health Alcohol and Substance Abuse Infectious Disease

Purpose for this disclosure:

_____ continuity of care _____ insurance _____ attorney/legal _____ other

I understand that I have the right to inspect the information prior to disclosure. I absolve the individual or agency identified above and the Board of Trustees of Arcadia University together with its officers and employees from any legal liability, which may arise from the disclosure of this information.

Patient Signature _____ **Date** _____