



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

(____)-(____)-(____)
Social Security Number

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 may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Arcadia University, Student Health Services. If I refuse to sign this authorization, my medical record/information will not be released. If this release is for the purposes of third party payment, the refusal to authorize could result in the assignment of financial responsibility to me, the patient, for services. This authorization will be considered valid for a 90-day period following the date of signature unless otherwise specified here _____. 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. I authorize the above agency to disclose protected information contained in my medical record.

Patient Signature: _____ Date: _____