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

Authorization for the Release of Confidential Health Information

1. Name: _____ /FR SO JR SR GRAD
(please print full name) (circle one)

2. Phone Number: _____ E-mail: _____

Student Address: _____

3. Date of Birth: _____ Student ID # _____ Year graduated: _____

4. Authorization:

- **I hereby authorize Arcadia University Student Health Services to release records of my care to:**

OR

- **I hereby authorize Arcadia University Student Health Services to obtain records of my care from:**

Name: _____
(Print name of person or entity to whom disclosure is to be made)
Address: _____
(Print address to which records are to be sent)

Phone: _____ Fax no: _____

5. Please release my records pertaining to the following date(s) of care: _____
6. Records to be released:

office visit notes: _____ x-ray films _____ other _____
x-rays reports _____ lab results _____

8. Purpose of Disclosure:
consultation_____ insurance ____attorney/legal ____continuity of care _____

9. Expiration Date or Event: _____

10. I understand that I may revoke an authorization, in writing, at any time, except to the extent that Arcadia University Student Health Services or other provider has taken action in reliance upon it.

11. I understand that information disclosed pursuant to the Authorization may be subject to re-disclosure. I absolve the individuals or entities identified above, Arcadia University, its Board of Trustees, officers and employees from any legal liability, injuries or damages which may arise from the disclosures made pursuant to this release.

12. I understand that Arcadia University Student Health Services will not condition my treatment by them on my signing this authorization.

_____ _____
Patient signature Date

_____ _____
Signature of Patient's authorized representative (if applicable) Date