AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATON

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed.

STEP 1: INFORMATION ABOUT YOU: PLEASE PRINT

STUDENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____
Street *City* *State* *Zip*

STEP 2: WHO HAS THE RECORDS NOW?

I hereby authorize: _____

Address: _____

_____

Fax Number: _____

STEP 3: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS?

To release the following information: Please Specify:

- ☐ All records
- ☐ Specific Information/Specific dates of treatment: _____

_____

To: _____

Address: _____

_____

Fax Number: _____

STEP 4: YOUR SIGNATURE:

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expireation date. Additional authorization for redisclosure beyond recipient is required.

_____ _____
Student's Signature *Date* *Witness Signature* *Date*

STEP 5: RELEASE FOR SENSITIVE INFORMATION:

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DESEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____
Student's signature *Date*

STEP 6: RELEASE FOR HIV INFORMATION:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION

_____ _____
Student's signature *Date*

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