SAINT FRANCIS UNIVERSITY
FOUNDED 1847

Student Health Center
P.O. Box 600
Loretto, PA 15940-0600

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT / CLIENT NAME _____ BIRTHDATE _____
ADDRESS _____ SS# _____

_____

NAME OF PATIENT/CLIENT AT TIME OF ADMISSION IF OTHER THAN ABOVE. _____

I HEARBY AUTHORIZE _____

_____TO RELEASE TO

_____

_____

(Complete Name and Address)

RECORDS REGARDING MY TREATMENT.

TREATMENT DATES: FROM _____ TO _____

PLEASE DISCLOSE THE FOLLOWING INFORMATION:

_____

_____

_____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THESE RECORDS BEFORE THEY ARE DISCLOSED OR USED.

THIS CONSENT AUTHORIZES THE RELEASE OF THE AFOREMENTIONED REQUESTED INFORMATION REGARDING MY TREATMENT, HOSPITALIZATION, EMERGENCY OR AMBULATORY HEALTH CARE AND/OR EVALUATION. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS CONSENT HAS BEEN TAKEN.

THIS CONSENT WILL EXPIRE ON _____. *(Date must be completed and is limited to no longer than six (6) months from the date on which it is signed.)*

FURTHER DISCLOSURE OF THE INFORMATION IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

THIS AUTHORIZATION AND REQUEST IS FULLY UNDERSTOOD BY ME AND IS MADE VOLUNTARILY ON MY PART.

I ACKNOWLEDGE THAT INFORMATION TO BE RELEASED MAY INCLUDE MATERIAL THAT IS PROTECTED BY FEDERAL LAW, AND MAY INCLUDE DRUG AND ALCOHOL ABUSE INFORMATION OR MENTAL HEALTH INFORMATION, OR BOTH. MY SIGNATURE BELOW AUTHORIZES RELEASE OF ALL SUCH INFORMATION.

_____ _____
(Date Signed) *(Signature of Patient / Client)*

_____ _____
(Date Signed) *(Signature of Parent/Guardian if student is under age 18)*

_____ _____
(Date Signed) *(Signature of Witness)*

VERBAL CONSENT REQUIRES SIGNATURE OF TWO WITNESSES. _____
(Signature of Witness)