

BRADLEY UNIVERSITY STUDENT HEALTH CENTER
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____
Name of Patient, Parent, Guardian or authorized person

Authorize _____
Name and Address of individual or organization requested to disclose records

___ To release to _____ OR
Name and Address of individual or organization to which disclosure is to be made

___ To obtain from _____
Name and Address of individual or organization to whom will be providing information

The relevant information from the medical record of: _____
Name of Patient

Whose birth date is ___/___/___ and whose social security number is ___ ___ ___/___ ___/___ ___ ___

Compiled for the time period of _____ to _____.

This information is being requested for the purpose of _____.

RECORDS TO BE DISCLOSED

For a complete release of records, please initial Part 1. For a partial release of records, note any exceptions in Part 2.

Part 1. _____ All medical records, including records concerning any mental health and developmental
Initials disabilities, alcohol and drug abuse records and HIV testing.

Part 2. _____ All medical records excluding information pertaining to:
Initials

_____ Health and developmental disabilities
Initials

_____ Alcohol and drug abuse records
Initials

_____ HIV testing
Initials

DISCLOSURE INFORMATION

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statutes or regulations. I have the right to revoke this consent by written statement at any time prior to release. I understand that I have the right to inspect and copy the information to be disclosed although in certain instances applicable states or regulation may place restrictions on this right. No information released shall be redisclosed to other individuals or agencies. This consent expires on the _____ day to _____, 20___, unless earlier revoked by me in writing.

Patient's Signature: _____
(If patient unable to sign, state reason and relationship of person signing for patient.) Date

Parent/Legal Guardian: _____
(State legal relationship to patient and legal basis on which consent is given.) Date

Witness who can verify identity of the patient: _____
Date