Westminster College

Student Health Center
319 South Market St., New Wilmington, PA 16172
0ffice: 724-946-7927 / Fax: 724-946-6308

RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Student Name _____Date of Birth_____ Date_____

I hereby authorize the Westminster College Student Health Center to release information to:

Name of recipient: _____

Contact person (if recipient is an entity): _____

Contact information: _____

I hereby authorize _____ to release information to Westminster College's Student Health Center: Westminster College Student Health Center
319 South Market Street
New Wilmington, PA 16172
Phone: 724-946-7927

The purpose of the disclosure is as follows:

□ Verification of attendance
□ Collaboration for treatment and continuity of care
□ Referral to another treatment provider
□ Discussing health issues with family
□ Insurance payment
□ Personal records
□ Other: _____

The information to be disclosed is **limited** to the following:

□ **ALL medical records**
□ Immunization information
□ Medical notes
□ Information related to a specific illness or date of visit: _____
□ Sexual health information
□ All medical records from dates including: _____
□ Other: _____

I understand I have the right to revoke this authorization in writing at any time. If I revoke my authorization, the information described above will no longer be used or disclosed for the reasons stated. Any disclosures already made with my authorization cannot be revoked retrospectively. I understand that information released pursuant to this authorization may be re-disclosed (depending on the party to whom released) and no longer protected under federal privacy law. Upon request, I can be provided with a copy of this release.

THIS AUTHORIZATION SHALL EXPIRE ON _____/_____/_____, BUT IN NO EVENT SHALL THIS AUTHORIZATION EXPIRE MORE THAN ONE YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED.

_____ _____ _____ _____
Student signature Date Witness Date

Special consideration is given to health records containing information that is considered sensitive in nature. To release the following information, a separate signature is required.

I am specifically requesting the disclosure of information related to the following to the party or parties listed above:
□ HIV/AIDS related information □ Sexually transmitted infection related information □ Alcohol/Drug related information

_____ _____ _____ _____
Student signature Date Witness Date