

Westminster College

Student Health Center

319 South Market St., New Wilmington, PA 16172

Office: 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:

- | | |
|---|--|
| <input type="checkbox"/> Verification of attendance | <input type="checkbox"/> Insurance payment |
| <input type="checkbox"/> Collaboration for treatment and continuity of care | <input type="checkbox"/> Personal records |
| <input type="checkbox"/> Referral to another treatment provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discussing health issues with family | |

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