AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Please complete this form thoroughly. Copies of your medical record cannot be released until this form is completed, signed by the student or legal guardian (if student is under age 18).

STEP 1 | Information About You

NAME ______________________________ **OTHER NAME** ______________

LAST *FIRST* *MI*

SOCIAL SECURITY # ______________ **DATE OF BIRTH** ______________ **PHONE #** ______________

COLLEGE STATUS: **F** **SO** **JR** **SR** **OTHER** *OR* **I HAVE GRADUATED IN THE YEAR** __________

RESIDENT STUDENT **COMMUTER STUDENT**

STEP 2 | Method of Release

(CHECK ONE)

PERSONAL PICKUP WITH A PHOTO ID
PERMISSION TO FAX
TELEPHONE/VERBAL COMMUNICATION
PHOTOCOPIES SENT BY MAIL

STEP 3 | To Whom do You Wish to Release Your Records or Obtain Your Records From?

RECORDS TO BE RELEASED TO ______________ **RECORDS TO BE OBTAINED FROM** ______________

NAME OF PERSON / FACILITY, ADDRESS, PHONE, OR FAX NUMBER IF APPLICABLE:

PLEASE SEND INFORMATION VIA CAMPUS MAIL TO THE NURSING AND HEALTH SCIENCES DEPARTMENT

RELEASE THE FOLLOWING INFORMATION:

IMMUNIZATION HISTORY
MENTAL HEALTH OFFICE VISITS
DIAGNOSTIC LAB WORK/X-RAYS (DESCRIBE) ______________________________
OTHER (DESCRIBE) ______________________________

FOR THE PURPOSE OF: CONTINUITY OF CARE WORK/SCHOOL OTHER ______________

STEP 4 | Authorization and Signature

I hereby authorize QuibinStudent Health Services to release the records as described above. This authorization is valid for one (1) year and may be revoked (except retroactively) at any time in writing prior to the expiration date. I do not give permission for any other use or re-release of this information. I release Quibin Student Health Services from all legal responsibility or liability that may arise from the act I have authorized above.

______________________ ________ ______________________ ________

PATIENT SIGNATURE *DATE* *WITNESS SIGNATURE* *DATE*

STEP 5 | Release of Protective Health Information

IF INFORMATION TO BE RELEASED INVOLVES ANY OF THE INFORMATION DESCRIBED BELOW, YOU MUST INITIAL THOSE THAT APPLY BELOW

I hereby authorize Quibin Student Health Services staff to release all information in such records including:

__________ Sexual assault records
__________ Sexually transmitted disease records
__________ Alcoholism/drug abuse records
__________ HIV/AIDS test or treatment