

# 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:

- Verification of attendance
- Insurance payment
- Collaboration for treatment and continuity of care
- Personal records
- Referral to another treatment provider
- Other: \_\_\_\_\_
- 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