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

Intereby authorize the Westminster College Student Health Center to release information to:	Student Name		Date of Birth	Date
Contact information: hereby authorize		_		
Contact information: I hereby authorize	Name of recipient:			
Center: Westminster College Student Health Center 319 South Market Street New Willmington, 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 Collaboration for treatment and continuity of care Personal records Discussing health issues with family The information to be disclosed is limited to the following: ALL medical records Information related to a specific illness or date of visit: Sexual health information All medical records from dates including: Other: Understand I have the right to revoke this authorization in writing at any time. If I revoke my authorization, the information 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	Contact person (if recipient is an entity): _			
Center: Westminster College Student Health Center 319 South Market Street New Willmington, PA 16172 Phone: 724-946-7927 The purpose of the disclosure is as follows:	Contact information:			
Insurance payment Personal records Other: Other: Personal records Other: Personal records Other: Personal records Personal records Other: Personal records Per	Center: Westminster College Student He 319 South Market Street New Wilmington, PA 16172		to release information to Westm	iinster College's Student Health
□ 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	 □ Verification of attendance □ Collaboration for treatment and continue □ Referral to another treatment provider 	_	□ Personal records	
□ Other:	 □ ALL medical records □ Immunization information □ Medical notes □ Information related to a specific illness □ Sexual health information 	or date of visit:		
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/				
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	described above will no longer be used or cannot be revoked retrospectively. I undo (depending on the party to whom release with a copy of this release. THIS AUTHORIZATION SHALL EXPIRE ON _	disclosed for the erstand that info	he reasons stated. Any disclosures alread formation released pursuant to this author er protected under federal privacy law. L	dy made with my authorization orization may be re-disclosed Upon request, I can be provided
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
	Special consideration is given to health refollowing information, a separate signat I am specifically requesting the disclosure	ure is required. of information	ing information that is considered sensit	parties listed above:
Student signature Date Witness Date Date	Student signature	 Date	 	 Date