STETSON UNIVERSITY

Student Health Service

Authorization for Release of Medical Records/Information

Your medical information may be released only with your written permission or by court order. Please indicate below which information is to be released and how it is to be released. Medical records faxed to your physician or referred physician will be done at no charge. Any medical records copied for any other reason may be assessed at a $1.00 per page charge.

Patient Name: _____ **Today's Date**: _____

Maiden Name: _____ **Date of Birth**: _____

Phone Number: _____ **Student ID#**: _____ **Date Graduated/Last Attended**: _____

Medical Records/Information to be released ***from***:

Name: _____ **Phone**: _____**Fax**: _____

Medical Records/Information Requested:

☐ **Immunization Records**

☐ **All Laboratory Reports** ☐ **Laboratory Report(s) for Specific Date(s)**: _____

☐ **All Radiology Reports** ☐ **Radiology Report(s) for Specific Date(s)**: _____

☐ **All Office Visits/Notes** ☐ **Office Visit(s)/Note(s) for Specific Date(s)**: _____

☐ **Complete Medical Record/History**. (Provide mailing address *and* fax number below)

The following information specifically requires your initials and will be released only if initialed.

HIV Testing _____ STD Testing ____ Mental Health Referrals _____ Substance Abuse Referrals _____ Sexual Assault _____

Medical Records/Information to be released ***to***:

☐ **Fax To** ☐ **Mail To** ☐ **Discuss With** ☐ **Pickup** | **Date**: _____

Name: _____ **Phone**: _____**Fax**: _____

Mailing Address: _____

Relationship to patient: _____

Purpose of request: _____

I understand that there may be sensitive information contained within these records regarding my health, and that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it. I hereby authorize the release of my health information as indicated above. I certify that I am the patient stated above and have signed this authorization voluntarily. This authorization expires on _____ (or, if unspecified, 180 days from date of signature).

Patient Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

Processed By: _____ **Date**:_____

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