AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Health Services   University of Scranton   Scranton, PA 18510-4507
Telephone (570) 941-7667   Fax (570) 941-4298

I ____ SS No. ______________DOB_______________
(print)
hereby authorize Student Health Services at The University of Scranton to:

[ ] release information to:

[ ] request information from:

Name:____

Address____

City/State/Zip Code____

The information will be used on my behalf for the following purpose(s):___________________________

____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____Medical records needed for continuity of care
_____Laboratory reports
_____Pathology reports
_____Other________________________________
(specify)

_____Medical chart notes
_____Immunization Records
_____Diagnostic Imaging reports

This authorization is limited to the following time period:____
(be specific)

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

______________________________________   ______________________________________
(Signature of patient.)   (Date)