Widener University

Medical Records Release Form

Name (print) (Maiden or other name)	Street Address	City	State, Zip
Cell Phone Local Phone	SS# _____-____-_____	Date of Birth ____/_____/____	Today's Date ____/_____/____

Are you a:		
Current Student ☐ Graduate ☐ Undergraduate	**Alumnus** Year Graduated: _____ You were a: ☐ Graduate Student ☐ Undergrad Student	**Withdrawal/Leave of Absence** Year: _____

I _____ authorize Widener University Student Health Services
(print name)

to release my _____ records from the year _____ through _____.
(be specific as possible)

Special Authorization, Please read: I DO NOT give my permission for the following information to be copied and disclosed. (Please check and initial)

_____ HIV related information _____ _____ Mental Health information _____
_____ Alcohol/Drug Treatment Information _____

Records should be: ☐ mailed to me at the address above ☐ held at the Health Center for pick up

☐ faxed to: Provider/Institution:_____

Fax No: _____ **Phone No**:_____

Attn: _____

☐ mailed to: Provider/Institution:_____

Address: _____

City, State, Zip: _____

_____ _____ _____/_____/_____
Signature of Patient Witness Date

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the 50 PA. Cons. STAT § 7111,42U.S.C. § 290 dd-2, 35 PA. Cons. STAT § 7601 and 20 U.S.C. § 1232g. These regulations prohibit the above person, organization or agency from making any further disclosure of this information without written consent.

Office Use
☐ Fee collected
☐ Date Completed
☐ Comment
Rev.