Anderson University Health Services

1100 East 5th Street
Anderson, IN 46012
Phone: 765.641.4222   Fax: 765.641.3976

Medical Record Release Authorization

Student Name:______________________________________ Birthdate:______________________
Student ID:_____________________________ Phone Number:____________________________
Street Address:____
City:_______________________________________ State:_________ Zip:___________________

Information to be disclosed:
☐ All Medical Records   ☐ Vaccination Records   ☐ Partial Records_____________________

I hereby authorize and request ___________________________________ to release copies of my health record to: ____
Address of agency (include phone/fax number if possible)________________________
____
____
____
Information to be released in the following manner: ☐ Verbally ☐Photocopy ☐Fax

☐ Permission to contact parent
Name and contact information:____
____
____

☐ Permission to contact others
Name and contact information:____
____
____

☐ Verbal information in case of emergency (may release to anyone related to care)
Name and contact information:____
____
____

This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. This shall not exceed 12 months. I am aware that I am under no obligation to disclose the requested information and acknowledge that this authorization may be revoked by me at any time, except to the extent that action has already been taken. I understand that by signing this consent I agree to disclose protected health information to the above listed parties. I am aware that the records disclosed might be records whose confidentiality is protected by either Federal and/or State regulations. These records may also include alcohol and/or substance abuse and mental health documentation as well as HIV results.

Students Signature____ Date______________

Witness Signature____ Date______________

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Health Services Office Only: *Date Completed*____________________________________

*Signature*_______________________________________