

**MEDICAL RECORDS RELEASE FORM**

ALLEGHENY COLLEGE - 520 NORTH MAIN STREET – MEADVILLE, PA 16335

By completing and signing this form, I authorize Allegheny College to release confidential health information about me, by releasing a copy of my medical records, or a summary, or narrative of my protected health information, to the specified person/organization/entity listed below. I understand that in order to complete this request, I must fill out this form *in full*.

\_\_\_\_\_  
Print Legal Name (Last, First)                      Allegheny ID#                      Soc. Sec. #                      Date of Birth

\_\_\_\_\_  
Street                      Apt.                      City                      State                      Zip

\_\_\_\_\_  
Phone (circle one)                      Mobile                      Home                      Work                      Email                      Fax

I authorize Allegheny College to disclose the information I specify below to **ONE**<sup>^</sup> of the following:

[ ] Myself, at the (circle one)                      mailing address                      email address                      fax number                      above.

[ ] \_\_\_\_\_  
Name / Organization / Entity

\_\_\_\_\_  
Street                      Apt./Suite                      City                      State                      Zip

\_\_\_\_\_  
Phone                      Fax                      Email

**RECORD TO BE DISCLOSED:**

Date of treatment from \_\_\_\_\_ to \_\_\_\_\_ (MM/YYYY)

*Check all that apply (ONLY SELECT THE INFORMATION YOU WANT INCLUDED):*

\_\_\_ Clinical Treatment Notes, \_\_\_ Lab Reports, \_\_\_ Radiology Reports, \_\_\_ Immunization Information, \_\_\_ HIV Related Information, \_\_\_ Sexual Assault Information, \_\_\_ Substance Abuse Information, \_\_\_ Psychological Related Information, \_\_\_ Other \_\_\_\_\_

**PURPOSE FOR DISCLOSURE:** \_\_\_\_\_

I understand that I have no obligation whatsoever to disclose any information from my record, and I understand that I may revoke this consent at any time by notifying Allegheny College in writing and/or specifying a date, time, event, or condition upon which my consent will expire without revocation. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I have read this form and have had it explained to me and I understand its content. Consent expires 90 days from the date of signature unless otherwise noted.

\_\_\_\_\_  
Student Signature (required)                      Date

\_\_\_\_\_  
Witness Signature (required)                      Date

<sup>^</sup>Please visit the Wellness Education Forms webpage for more information on method of information return, turnaround time, and other notes on Pennsylvania law's and the release of medical information.