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**^ 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

^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.

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