

**AUTHORIZATION TO RELEASE PATIENT-RELATED
INFORMATION INCLUDING MEDICAL RECORDS**

Patient Name: _____ Maiden or Previous Name(s): _____
Social Security Number: _____ Date of Birth: _____
Last Year of Attendance at Wheaton College: _____

I. Authorization for Release of Information

I, the undersigned, authorize _____ and its employees and agents to release and disclose all information about me that they possess (except for the release of information concerning substance abuse, mental health, HIV, or AIDS, unless I have specifically authorized the release of such information in Section II below) to the Recipient(s) identified in Section III below. I understand that unless I state otherwise in this authorization, the information release may include intake questionnaires, immunization records, health history records, physical examination records, consultation reports, diagnostic reports, operative reports, laboratory test reports, photographs, videotapes, X-rays, digital or other images, discharge summaries, treatments, prescriptions, and notes of health care professionals. I also authorize the release of information received, obtained, or created after the date on which this Authorization is signed as long as such information is released during the effective period of this Authorization and pursuant to a legitimate request for such information.

II. Specific Authorization for Release of Protected Information

I specifically authorize the release of information related to the following:

- acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV)
 - substance abuse (drugs(s) or alcohol)
 - mental health, behavior, or psychological/psychiatric care or conditions
- (To release this information, you must sign here and at the end of this form.)

Signature of Patient or Parent or Legal Guardian

Date of signing

III. Scope of Disclosure and Duration of Authorization

The information released is to be disclosed to the following persons or entities (the "Recipient(s)"): Wheaton College – Student Health Services, 501 College Avenue, Wheaton, IL 60187; Fax 630/752-5575; Phone 630/752-5072

for the purpose of: _____. It includes the information identified above regarding all consultations/treatments, except: _____

_____ (specify exceptions, if any).

I understand that I have the right to inspect the disclosed information at any time.

Unless otherwise revoked, this Authorization will expire on _____
(or on the 365th day from the date of signing if no date is specified).

A photocopy, facsimile, or exact reproduction of this signed Authorization shall have the same force and effect as the original.

I have read and fully understand the provisions of this Authorization.

Patient's Printed Name

Patient's Signature

Date

Witness's Printed Name

Witness's Signature

Date

(Rev. 6/99)