



ALVERNIA UNIVERSITY
HEALTH AND WELLNESS CENTER
610-568-1467 / fax 610-796-8422

Consent for Release of Protected Health Information

I, \_\_\_\_\_, request/authorize \_\_\_\_\_
(name of student)

to disclose my: (Please initial)

Table with 2 columns: Health Service Records and Counseling Service Records. Includes checkboxes for Physical Exam, Medical History/Immunization Record, Progress Notes, Lab/X-ray Results, PPD Results, Counseling Services Summary, Contact with Faculty/Staff, Contact with Outside Agency, and Confirmation of Attendance.

to: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_
Date

\_\_\_\_\_
Patient/Student Signature

\_\_\_\_\_
Print Name

\_\_\_\_\_
Date of Birth

\_\_\_\_\_
Date

\_\_\_\_\_
Witness Signature

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon \_\_\_\_\_.