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)

Health Service Records	**Counseling Service Records**
_____ Physical Exam	_____ Counseling Services Summary
_____ Medical History/Immunization Record	_____ Contact with Faculty/Staff
_____ Progress Notes	_____ Contact with Outside Agency
_____ Lab/X-ray Results	_____ Confirmation of Attendance
_____ PPD Results	

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 office or practice, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon*_____.