

# ALVERNIA UNIVERSITY

## HEALTH & WELLNESS CENTER Consent for Release of Information

I, \_\_\_\_\_, request/authorize Alvernia University Health and Wellness Center  
(name of student)  
to disclose my: **(Please initial)**

\_\_\_\_\_ Physical Exam

\_\_\_\_\_ Medical History

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Lab Results

\_\_\_\_\_ PPD Results

\_\_\_\_\_ Counseling Records

To: \_\_\_\_\_  
(Name or title of the person/organization to which disclosure is to be made)

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

For: \_\_\_\_\_  
(Purpose of disclosure)

\_\_\_\_\_  
Date

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

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

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

*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 \_\_\_\_\_.*  
(specific date, event or condition)

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Below the line to be filled out by Alvernia University Health and Wellness Center Staff.

Protected Health Information released on \_\_\_\_\_ to \_\_\_\_\_

Signature of person releasing PHI \_\_\_\_\_ Date \_\_\_\_\_