ALVERNIA UNIVERSITY

Health & Wellness Center
Veronica Hall—Lower Level
610-568-1467
h&w@alvernia.edu

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with regulations contained within the **Family Education Rights and Privacy Act (FERPA),** Alvernia University Health and Wellness Center will maintain all student medical information as Treatment Records, separate from students' Education Records. Information from a student's Treatment Record will only be disclosed to designated parties with the written consent of the student, *with the exception of a health or safety emergency*.

I hereby consent to authorize the Alvernia University Health and Wellness Center to discuss my health information with the following people:

Emergency Contact	Relationship	Phone Number
Additional Contact	Relationship	Phone Number

Date:_____

Signature:_____

Printed name:_____

My authorization may be revoked at any time by completing the portion in the box below.

Please do not complete this portion until you would like to revoke authorization:

On this date, I would like to revoke the above authorization and discontinue the release of information to those identified above.

Date:_____

Signature:_____

Printed name:_____