

# ALVERNIA UNIVERSITY



Health & Wellness Center  
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## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Pennsylvania state law (specifically 35p.s. Section 10101) requires any minor who is eighteen (18) years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

I hereby consent to authorize the Alvernia University- Health and Wellness Center to release information about my medical condition to my parents/legal guardian.

### Purpose of the Disclosure:

The information may be released in order to keep my parents/legal guardians informed about my general health and medical condition.

**My authorization may be revoked at any time.**

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_

**We will ask you to verify this form annually.**

_____	_____	_____	_____	_____	_____
Date	Initials	Date	Initials	Date	Initials
_____	_____	_____	_____	_____	_____
Date	Initials	Date	Initials	Date	Initials

***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 my parents/legal guardian.

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_