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: ________________________________