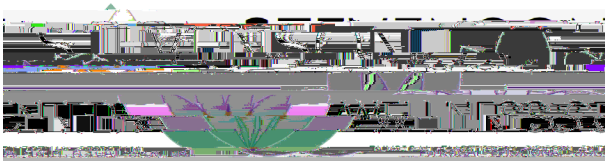

100 Campus Circle, Owings Mills, MD 21117 | P: 443-352-4200 | F: 443-352-4201 | Wellness@stevenson.edu

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Please allow approximately 48 hours (two business days, excluding weekends and holidays) for records to be available. Every attempt will be made to process requests for medical records within 48 hours.

PATIENT INFORMATION

Patient Name #: SU ID

Former Name (if any): DOB:

Phone # Cell Phone #

Initial Term Entering SU as a full-time student: ◯ Fall ◯ Spring Year:

PURPOSE OF THIS REQUEST

☐ Healthcare ☐ Transfer to College/University

☐ Personal ☐ Other

INFORMATION TO BE RELEASED/OBTAINED

*The Wellness Center retains records for 7 years from original date of entry into Stevenson University.

◯ I authorize SU Wellness Center to release information to

I authorize SU Wellness Center to obtain information from

Name of Student, Provider or Facility

Address

City State Zip

Phone # (include area code) Fax # (include area code)

AUTHORIZATION VALID FOR

HOW INFORMATION WILL BE RELEASED/OBTAINED

◯ Pick up medical information at the Stevenson University Wellness Center

◯ Mail to:

Name of Student, Provider or Facility

Address (if other than SU Wellness Center)

City State Zip

◯ Fax to: ◯ Wellness Center Fax: 443-352-4201

SPECIFIC INFORMATION TO BE RELEASED

Release the following medical records:

Student Health Form (Immunization Record, Physical Exam, TST (Tuberculin Skin Test) Results)

Flu shot records

Women's Health Annual including PAP Results

X-Ray Results

Lab Results Date:

Other:

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Stevenson University Wellness Center. If I refuse to sign this authorization, my medical record/information will not be released. I absolve the individual or agency identified above and the Board of Trustees of Stevenson University together with its officers and employees from any legal liability, which may arise from the disclosure of this information. I authorize the above agency to disclose protected information in my medical record. I understand that my medical record may be transmitted electronically by fax and may be received in error by a third party. In this event, I absolve the Stevenson University Wellness Center of all liability. I am also aware that the medical records to be released may contain information related to sexually transmitted infections, alcohol/dru

FOR INTERNAL USE ONLY BY THE SU WELLNESS CENTER

Authorization to Release Medical Records Form Received:

{ Front Desk { Fax { Email Date:_____ Time:_____ Initials:_____

Records released from SU Wellness Center as follows (mark appropriate box):

O Records Mailed

O Records to be picked up

O Records Faxed

Date copied and initials:_____

Records requested to be sent to SU Wellness Center from another provider or organization as follows (mark appropriate box):

O Records Request Mailed

O Records Requested Faxed

Date Records Requested and initials:_____

Date Records Received and initials:_____

SU Wellness Center notes (if any) regarding this authorization:

[redacted]