INDIANA WESLEYAN UNIVERSITY
HEALTH CENTER

4201S Washington ST
Marion, IN 46953
Phone: (765)677-2206
Fax: (855) 876-8285

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name_____ Date_____

Address_____
Number street apt# city state zip

Date of Birth_____ Phone _____

I authorize Indiana Wesleyan Wildcat Health Clinic to release or obtain the following medical information:

___ Chart Notes
___ Lab Results
___ ER Records
___ Medication(s)
___ Immunization Record
___ Test(s)/Procedure(s)
___ Mental Health Records
Other _____

_____ Release to:
_____ Obtain from:

_____
Name of agency information is to be release and/ or obtain from

_____
address city state zip

_____ _____
phone number fax number

I understand the information may be communicated via fax, photocopy, verbal communication, telephone, voice mail, and or direct mail.

The information being disclosed/obtained is for the following purpose:
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

I understand that I may revoke this release at any time in writing except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date below. I also understand that this release may include medical records of treatment for physical and/or emotional illness including the treatment of alcohol or drug abuse, HIV, AIDS or AIDS-related and/or communicable disease information may also be released.

*****MUST ATTACH A COPY OF YOUR PHOTO ID

Expiration date of authorization: _____
(Enter date of expiration ONLY if other than 1 year)

Signature of patient (if over 18) _____ date_____

Signature of parent/guardian (if patient is under 18) _____date_____