DePauw Health Wellness Center
800 S. Locust St.
Greencastle IN 46135
Phone: (765) 658-4555
Fax: (765) 658-4558
DePauwHealth.org

Authorization for Release of Medical Information

Patient Information:

Name:_____Date of Birth:_____
Student ID #_____Graduation Year_____Phone:_____

Release of Records: *I authorize the DePauw University Wellness Center to:* (Check one or both)

☐ Release information to

☐ Obtain information from

Name/Organization:_____

Address:_____

City/State/Zip Code:_____

Telephone:_____

Fax (must be in secure location):_____

Type of Records: *(Must check yes or no in each section)*

☐ Yes ☐ No I authorize the release of mental health information.

☐ Yes ☐ No I authorize the release of information regarding drug or alcohol treatment.

☐ Yes ☐ No I authorize the release of Sexually Transmitted Disease information including HIV/AIDS.
I understand that the person(s) listed above must have my written permission before disclosure of this information to anyone.

Specific medical information to be released:_____

_____

_____

Reason for Release:

☐ Facilitate treatment/coordination of care

☐ Readmission

☐ Other_____

I understand that this authorization expires 60 days from the date of signature. I may revoke this authorization in writing at any time. The revocation will be effective on the date of receipt.

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature:_____Date:_____

Witness:_____Date:_____