

DePauw Health Wellness Center
1 East Olive
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: _____