Widener University

Student Health Services One University Place Chester, Pa. 19013

Medical Records Release Form

Name (print) (Maiden or other name)	Home Street Address	Home City	Home State, Zip
Cell Phone	University ID Number ________________	Date of Birth ____/_____/____	Today's Date ____/_____/____

Please check your status:

- ☐ Current Undergraduate Student ☐ Current Graduate Student
- ☐ Alumnus – Year of Graduation _________ Did you graduate from an undergrad or grad program?
- ☐ Withdrawal/Leave of Absence - Year _________

I ________________________________ authorize Widener University Student Health Services to release
(print name)

my _____________________________________ records from the year __________through __________.
(be specific as possible)

I DO NOT GIVE PERMISSION FOR THE FOLLOWING INFORMATION TO BE DISCLOSED (as defined by applicable state and federal laws): (Please check)

☐ HIV related information ☐ Mental Health information ☐ Alcohol/Drug Treatment Information

Expiration: This Authorization is good until the following date / event: ____________________________________
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

I request that my records be:

☐ mailed to me at the above address ☐ held at the Health Center for pick up

☐ faxed to: Provider/Institution: ______________________________ Attn: _____________________
Fax No: ___________________ Phone No: _________________

☐ mailed to: Provider/Institution: _______________________________________
Address: _______________________________________
City, State, Zip: ____

This information is being disclosed to the following person or agency from records whose confidentiality may be protected by the PA Law, Act 62 and/or Pennsylvania P.L.817 and/or Federal Public Law 93-282 and/or PA Law, Act 148. These regulations prohibit the above person or agency from making any further disclosure of this information without prior written consent.

I understand that I have no obligation to disclose information from my record and that I may revoke this consent at any time by notifying Health Services in writing. I have had this form explained to me and I understand its contents. I also understand that my signing or revoking this authorization will not affect my health care treatment or coverage under any health plan.

____________________________________ ________________ ______/______/______

Signature of Patient Witness Date

3.14