Doane University Student Health Services

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: The patient must complete this form in its entirety in order for the Doane University Student Health Services to release or request any medical information. The patient must be specific as to the nature of the information to be released and the purpose for which it is requested. The patient is entitled to receive a copy of this release.

(Please Print)

____ _______________

Last Name First MI Date of Birth

Date(s) of treatment:______________________________ Patient's Phone No:________________________

I hereby authorize and request copies of my medical records from:

Name:____

Address:____

Phone No:_______________________________________ Fax No:_______________________________

To be released to:

Name:____

Address:____

Phone No:_______________________________________ Fax No:_______________________________

Check information requested: ____Lab results ____ X-ray report ____Immunization record
____Physical exam ____Consultation report ____Discharge report ____
____Other (specify____
____

Reason for request: ____Continuity of care (follow up) ____Consultation ____Insurance
____School transfer ____Personal

Information to be: ____Mailed ____Picked up ____Faxed ____
____

____This authorization is valid for 90 days after signature. This consent is subject to revocation by the patient or his/her representative at any time, in writing except to the extent that action has been taken.

____This information is confidential and there shall be no further disclosure without the written authorization of the patient or his/her legal representative.

____I understand the release of medical information may take ten (10) working days to process.

_________________________________ ___________________________ ______________________

Signature of patient or legal representative Relationship to patient Date

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Witness (Student Health Services Staff)