

DePauw University Health Services
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CONSENT TO RELEASE INFORMATION

Patient Information:

Name _____

Date of Birth ____/____/____

Phone Number _____

Year of graduation _____

I hereby authorize release of the information below to be faxed/mailed (circle one) to:

Name _____

Address _____

Fax _____

Phone _____

Information requested:

- Immunization records
- Pap results
- Laboratory and/or radiology reports
- Entire record, including HIV/STD results
- Other: _____

I understand that my records are protected under confidentiality regulations and cannot be released or re-released without my written authorization unless required by law. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred. This consent will expire at the end of 60 days.

Patient signature _____ Date ____/____/____