



TEMPLE UNIVERSITY  
A Commonwealth University

Ambler Student Health Services  
Darwin Module  
580 Meetinghouse Road  
Ambler, PA 19002  
Tel: (267) 468-8490  
Fax: (267) 468-8492

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
FROM STUDENT HEALTH SERVICES**

I, \_\_\_\_\_, hereby authorize  
(Name) (Temple ID#)

Temple University Student Health Services to release my medical records to:

\_\_\_\_\_  
(Name of organization, physician, or other person receiving the records)

\_\_\_\_\_  
(Address and/or fax number)

Information to be released:

All Records (This could include information about my sexual activity and sexually transmitted diseases)

I understand that any information disclosed in response to this request will NOT include information related to my treatment for HIV/AIDS, mental health, alcohol and/or substance abuse unless specifically checked below:

- Information about my HIV status
- Information about my mental health
- Information about alcohol and/or substance abuse

Specific information—please write below what information we may release.

This can be limited to a specific medical condition or to visits during a certain time period. For example, it may be from a certain date or about a specific injury or illness.

\_\_\_\_\_  
\_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time

I understand that my records are protected under the Federal Privacy Act PL 93-575, the Federal Alcohol and Drug Abuse Act PL 92-282, the Pennsylvania Mental Health Procedures Act, 1976, and the Pennsylvania Confidentiality of HIV-Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to this office and/or my consent automatically expires under the circumstances previously described.

\_\_\_\_\_  
(Signature) (Today's Date)

Best Number to Reach You: \_\_\_\_\_