



TEMPLE UNIVERSITY
A Commonwealth University

Student Health Services, 4th Floor
1810 Liacouras Walk (066-04)
Philadelphia, PA 19122
Tel: (215) 204-7500
Fax: (215) 204-4660

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

I, _____, hereby authorize
 (Name) (Temple ID#)
 Temple University Student Health Services

To release information to: To exchange information with:

Name-(health facility, physician, other institution, etc....)			
Street Address	City	State	Zip
Phone #	Fax #		

Requests for medical records take 7-10 business days to process. Fees may apply.

SPECIFIC INFORMATION TO BE RELEASED—CHECK EACH CATEGORY THAT YOU WANT RELEASED

- Immunizations and/or Tuberculosis Testing
- Lab test results (please specify which tests) _____
- Most recent physical examination
- Imaging reports (please specify which: ultrasound, X-ray, MRI, etc.) _____
- Medical records regarding a specific condition: _____
- Medical records from a specific time period PLEASE SPECIFY DATE RANGE: _____
- Most Recent Annual GYN Progress Notes/Records **AND** Pap Cytology/Colposcopy results

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 I specify below:

- Information about my HIV status _____
- Information about my mental health _____
- Information about alcohol and/or substance abuse _____
- All Records (**This could include information about my sexual activity and sexually transmitted diseases**) _____

INITIAL EACH ITEM THAT YOU WANT INCLUDED IN THIS REQUEST

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: _____