



TEMPLE UNIVERSITY  
A Commonwealth University

Ambler Student Health Services  
Darwin Module  
580 Meetinghouse Road  
Ambler, PA 19002  
Tel: (215) 283-1430  
Fax: (215) 283-1686

**AUTHORIZATION TO SEND MEDICAL INFORMATION TO STUDENT  
HEALTH SERVICES**

I \_\_\_\_\_ authorize  
Patient's name and date of birth (or sticker)

\_\_\_\_\_  
Physician, clinic, or hospital

TO RELEASE INFORMATION TO TEMPLE STUDENT HEALTH SERVICES

Office Address: \_\_\_\_\_  
\_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

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 you want sent. This can be limited to a specific medical condition or to visits during a certain time period. For example, it maybe 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: \_\_\_\_\_