TEMPLE UNIVERSITY
A Commonwealth University

Student Health Services, 4th Floor
1700 N.Broad Street
Philadelphia, PA 19121
Tel: (215) 204-7500
Fax: (215) 204-4660
medicalrecords@temple.edu

AUTHORIZATION TO SEND MEDICAL INFORMATION TO STUDENT HEALTH SERVICES

I _____ authorize
Patient's name and date of birth

Records Released From:

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

☐To release information to: ☐ To exchange information with:

_____ at TEMPLE UNIVERSITY STUDENT HEALTH SERVICES
(name of provider or staff requesting records)

CHECK *ONLY* THE INFORMATION THAT YOU WANT RELEASED

___**Immunizations** and/or **Tuberculosis Testing**
___**Lab test results** (please specify which tests)_____
___**Imaging reports** (please specify which: ultrasound, X-ray, MRI, etc.)_____
___Records regarding a **specific condition**:_____
___Records from a **specific time period** PLEASE SPECIFY DATE RANGE: _____
___Most recent **physical examination**
___Last 3 **Pap results** ___All **colposcopy/biopsy** reports ___Results of most recent **STD Testing**

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)

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: _____