CONSENT FOR RELEASE OF MEDICAL INFORMATION

With this form, you authorize the release of your medical health information. Print neatly and complete all fields. Questions may be emailed to: health@andrew.cmu.edu

IDENTIFY YOURSELF (You are the Client)

Client's Last Name		*First Name*	*MI*	*Date of Birth (mm/dd/yyyy)*
Address				
9-digit Carnegie Mellon Student Account # *(This is your SS#, or a 9-digit number starting with 999 or 700.)*	*Email address*			*Phone #*

If applicable, please indicate the semester and year of your Carnegie Mellon graduation. (ex: Spring, 2007) ___________________

Otherwise, specify the semester and year when you last attended. (ex: Spring, 2007) ________________________

IDENTIFY THE FACILITIES SENDING AND RECEIVING YOUR MEDICAL INFORMATION

Carnegie Mellon Student Health Service 1060 Morewood Ave, Pittsburgh, PA 15213 Phone: (412) 268 2157 Fax: (412) 268 6357 *You may specify a particular staff member here if you wish:* ______________________	☐ is sending information to or ☐ is receiving information from	*Name of Facility or person:* *Address:* *Phone:* *Fax:*

SPECIFY THE INFORMATION TO BE RELEASED

Why do you want the information released?

____

For which dates of service do you want medical records released?

____

What categories of information do you wish to have included:

- ☐ Immunization records and health history only
- ☐ All medical records **except sensitive documents** (substance or alcohol abuse, domestic violence, sexual assault, HIV related)
- ☐ All medical records, **including sensitive documents**.
- ☐ All medical records, **except** medical records from other facilities
- ☐ Other (please specify in writing here what records you are requesting):

____

On what day do you wish this consent to expire?

____
(mm/dd/yyyy)

In order to protect your medical records information, this consent must have a time limit; you are not permitted to grant consent that does not expire. Timeframe cannot exceed one year from date of Client/Auth Representative signatures below. If left blank, consent expires 90 days after signature date.

Client may terminate this consent at any time by sending a written request to the facility/person identified above to release records. Receipt of a termination request will cancel future actions, but cannot reverse the release of information already completed.

CERTIFY THIS REQUEST

____ ____________________
Client's signature (if not 18, an Authorized Representative must sign below) *Date Client signed (mm/dd/yyyy)*

______________________ ______________________ ____________________
Authorized Representative's signature *Authorized Representative's relationship to act on behalf of client* *Date Auth. Rep. signed (mm/dd/yyyy)*

____ ____________________
Signature of a Facility Staff Member witnessing this signature of Client *Date Witness signed (mm/dd/yyyy)*

Witness must verify patient identity (medical id number, visit history, etc.) If form is received by FAX, verification is to be done by phone.

RETURN THIS FORM TO: Student Health Services, Carnegie Mellon, 1060 Morewood Ave, Pittsburgh, PA 15213 FAX: 412 268 6357

Signature of Facility staff member that completed the release, and the date completed: ________________________________