Millersville University
HEALTH SERVICES

Witmer Building
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Millersville, PA 17551
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Phone: 717.871.5250
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____ M# _____

Address: _____ City: _____

State: _____ Zip: _____ Phone#: _____

I, the above-named patient, do hereby authorize:

□ My medical records to be released **TO** Millersville University Health Services

□ The release of my medical records (as specified below) **FROM** Millersville University to:

Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

I request that my records to be sent via: US Mail _____ Fax _____

The information requested is:
□ All medical records □ Records from (dates) _____ to _____
□ Records related to _____
□ Most recent physical examination and immunization records
□ Other (please specify) _____

In the event that these records contain protected information such as sexual health-related information (including HIV/AIDS/STI's), Mental Health records, Drug/Alcohol treatment records, and/or Sexual Abuse, I specifically.
□ authorize release of such information □ do not authorize release of such information.

I am requesting these records for the purpose of:
□ continued care □ personal request □ Other

Disclosure: I understand that Millersville University Health Services (MUHS) will only forward MUHS records, we will not forward other physician/facility medical records. I understand that I have the right to sign or not sign this form and that my treatment will not be affected by that decision. This authorization is in effect during the time I am a student at Millersville University; however, I have the right to revoke this authorization at any time in writing to MUHS.

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Witness Signature: _____