STEVENSON
UNIVERSITY

Wellness Center
100 Campus Circle
Owings Mills, MD 21117

Authorization to Release Patient Medical Information

Please allow approximately 48 hours (two business days; excluding weekends and holidays) for records to be available. Every attempt will be made to process requests for medical records within 48 hours.

PATIENT INFORMATION

Patient Name (please print):___________________________ SSN (last 4 digits): _________________

Former Name (if any): _________________________________ DOB: ____________________________

Phone #: (_____)_____________________ Cell Phone #: (_____)____________________

Initial Term Entering SU as a full-time student: ☐ Fall _____ ☐ Spring ______

PURPOSE OF THIS REQUEST

- ○ Healthcare
- ○ Other
- ○ Personal
- ○ Transfer to College/University

INFORMATION TO BE RELEASED/OBTAINED

*The Wellness Center retains records for 7 years from original date of entry into Stevenson University.

- ○ I authorize SU Wellness Center to release information to:
- ○ I authorize SU Wellness Center to obtain information from:

____
Name of Student, Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone # (include area code) Fax # (include area code)

AUTHORIZATION VALID FOR

- ○ This request only
- ○ One year from the date of this authorization

HOW MEDICAL INFORMATION WILL BE RELEASED/OBTAINED

- ○ Pick up medical information at the Stevenson University Wellness Center
- ○ Mail to:
  Address (if other than SU Wellness Center): ________________________________
  ____
  City State Zip
- ○ Fax to: Fax# (_____) ________________ ○ Wellness Center Fax# (443)352-4201

SPECIFIC INFORMATION TO BE RELEASED

Release the following medical records:

- ○ Student Health Form (Immunization Record, Physical Exam, TST (Tuberculin Skin Test) Results)
- ○ Women's Health Annual including PAP Results
- ○ Other:___________________________
  ____
- ○ X- Ray Results
- ○ Lab Results Date: ________________
- ○ Inpatient Discharge Summary from hospitalization on Date(s):
  ____
- ○ Emergency or Urgent Care center visit(s) from Date(s):
  ____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Stevenson University Wellness Center. If I refuse to sign this authorization, my medical record/information will not be released. I absolve the individual or agency identified above and the Board of Trustees of Stevenson University together with its officers and employees from any legal liability, which may arise from the disclosure of this information. I authorize the above agency to disclose protected information in my medical record. I understand that my medical record may be transmitted electronically by fax and may be received in error by a third party. In this event, I absolve the Stevenson University Wellness Center of all liability. I am also aware that the medical records to be released may contain information related to sexually transmitted infections, alcohol/drug use, or mental health and my signature authorizes the release of this information.

Patient's Signature: ____ Date: _________________

Patients Name Printed:____

Parent or Legal Guardian Signature, if patient is under 18 years of age: ___________________________

Parent or Legal Guardian Name Printed: ____

Revised 06/29/11

FOR INTERNAL USE ONLY BY
SU Wellness Center

Date and time patient filled out Authorization to Release Medical Records Form:
Front Desk: ____
Fax: ____
Email: ____

Records **released from** SU Wellness Center as follows (mark appropriate box):

- ○ Records Mailed
- ○ Records to be picked up
- ○ Records Faxed

Date copied and initials: _______________

Records requested to be **sent** to SU Wellness Center from another provider or organization as follows (mark appropriate box):

- ○ Records Request Mailed
- ○ Records Requested Faxed

Date Records Requested and initials: _______________
Date Records Received and initials:_________________

SU Wellness Center notes (if any) regarding this authorization ___________________________________

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