100 Campus Circle, Owings Mills, MD 21117 | P: 443-352-4200 | F: 443-352-4201 | Wellness@stevenson.edu

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: ____ SU ID #:_______________

Former Name *(if any)*:____________________________________ DOB: ________________

Phone #:_________________________________ Cell Phone #: ___________________

Initial Term Entering SU as a full-time student: Fall Spring Year:_______________

PURPOSE OF THIS REQUEST

Healthcare

Transfer to College/University

Personal

Other

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

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

AUTHORIZATION VALID FOR

This request only

One year from the date of this authorization

HOW INFORMATION WILL BE RELEASED/OBTAINED

Pick up medical information at the Stevenson University Wellness Center

Mail to:

____
Name of Student, Provider or Facility

____
Address *(if other than SU Wellness Center)*

______________________ ____________ ____________
City State Zip

Fax to: ______________________ 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)

Flu shot records

Women's Health Annual including PAP Results

X- Ray Results

Lab Results Date:

Other:

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:______________________________

FOR INTERNAL USE ONLY BY THE SU WELLNESS CENTER

Authorization to Release Medical Records Form Received:

○ Front Desk ○ Fax ○ Email Date:________________ Time:____________ Initials:______

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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