Slippery Rock University

Health Center
Division of Student Affairs

Student Health Center Slippery Rock, PA 16057
724-738-2052 phone
724-738-2078 fax
724-738-4505 TDD
www.sru.edu/offices/student-health-services

Authorization for Release of Information

I, _____ DOB _____
(Student Name)

_____ Cell Phone _____
(Student Address)

Home Phone _____

authorize
- ☐ Butler Health System
- ☐ Grove City Medical Center
- ☐ SRU Director, Student Support
- ☐ Center for Community Resources
- ☐ SRU Counseling Center (x4532) fax
- ☐ Clarion Psychiatric Center
- ☐ SRU Office of Disability Services (x4399) fax

_____ FAX _____
(Name of Physician, Practice, Facility)

_____
(Address)

and:

_____ FAX _____
(Name of Physician, Practice, Facility)

_____
(Address)

to exchange information as deemed medically necessary regarding my illness/injury:

_____ date of service: _____, and to release to each other copies of my medical records, appointment history, diagnostic reports, diagnosis, prognosis, treatment plan and/or any other related data.

General Authorization

I understand also that I may cancel this authorization at any time except to the extent that action has been taken in reliance thereon. This consent will remain in effect for one year from the date I signed this Authorization in order to accomplish its purposes. I understand that I may revoke this consent at any time by submitting a written request.

Student Signature **(If Student is less than eighteen years of age at the time of request, parental consent is also required.)**

Witness (or Parent if Student is under 18 years of age)

Date

Special Authorization

I understand that my medical records may contain drug/alcohol treatment and/or mental health information and I give special authorization to the health care provider/ facility to release this information in my records to the person, physician, facility named above for the stated purpose. I understand that I may revoke this consent at any time by submitting a written request.

Student Signature **(If Student is less than eighteen years of age at the time of request, parental consent is also required.)**

Witness (or Parent if Student is under 18 years of age)

Date

Valid beginning ___/___/___
Expiration ___/___

IMPORTANT INFORMATION ABOUT THESE RECORDS: The records and information that have been disclosed to you are records whose confidentiality is protected by State and Federal statute. Federal regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.