Meredith College Student Health Center
3800 Hillsborough Street
Carroll Hall
Raleigh, NC 27607
919-760-8535 (phone) 919-760-8534 (fax)

Authorization To Release Health Information

Patient Name:_____ Birth Date:_____ Graduation Year:_____

Meredith College Student ID Number:_____ Phone Number:_____

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Please check one and provide the requested information:

□ I hereby authorize _____to disclose my health information to Meredith College Student Health Center.

□ I hereby authorize Meredith College Student Health Center to disclose my health information to the following organization(s) or person(s):

Name(s)/Organization: _____

Address: _____City:_____ State:_____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release: ___Personal use ___ Continuation of care ___Parental/Guardian Communication ___
Other:_____

Information to be released: ___ Entire Medical Record ___Women's Health (Exam, Pap, Lab) ___
Immunization Records ___ Other:_____

Treatment Dates: _____

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I understand that signing this authorization is voluntary and I may refuse to sign it. Meredith College Student Health Center will not condition my treatment on receiving my signature on this Authorization.

I understand that information authorized by this release carries with it the possibility of unauthorized disclosure by the person(s)/organization(s) receiving the information and would no longer be protected under federal privacy regulations.

I understand that I have the right to revoke/cancel this authorization at any time. A written revocation/cancellation must be presented to Meredith College Student Health Center. I understand that the revocation/cancellation will not apply to information which has already been released in response to this Authorization.

This authorization, unless revoked/canceled, will expire in one (1) year or _____ (specify date, if less than one year) from the date of signature.

Signature_____ Date_____
(Patient or Parent/Guardian-if patient is 17 years or younger)

Witness _____ Date_____

Office Use Only:

□ Faxed □ Mailed □ Patient Picked Up □ Emailed

Date Sent:_____ By Whom:_____