PennState Altoona

Health and Wellness Center

CONSENT TO RELEASE INFORMATION

_____ ____/____/____ _____

Patient Name (Please Print) **Date of Birth** **PSU ID# or SSN**

I authorize the Health and Wellness Center, 3000 Ivyside Park, Altoona, PA 16601, to Disclose/Receive (circle one) information contained in my record to/from (circle one):

Name _____Organization/Agency:_____Fax:_____

Address _____City _____ State _____ Zip_____

Purpose for disclosure: ☐ **Continuation of Care** ☐ **Payment of Claim** ☐ **Retroactive Withdrawal**
☐ **Other_____**

The information to be released is confined to the following:

Counseling/Psych. Services	Health Services/Health Education	Student Disability Resources
☐ Attendance ☐ Diagnosis/Assessment ☐ Treatment Plans ☐ Psychosocial History ☐ Treatment Summary ☐ Other: _____	☐ Health Hx/Immunization Records ☐ Physical Exam ☐ GYN. Exam ☐ Treatment Notes ☐ Lab Reports ☐ X-ray Reports ☐ Other:_____ ☐ AWARE/IMPACT Program Attendance and Compliance	☐ Documentation of my Disability ☐ Accommodation Forms ☐ Other:_____
I understand that my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing below: ☐ Alcohol/Drug Use ☐ Mental Health ☐ HIV and/or AIDS ☐ Sexual Assault		

Specific information to be disclosed: ☐ copies ☐ verbal consultation.

- I understand this release is valid _____ days or for one year from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Health and Wellness Center. The staff of the Health and Wellness Center can not be held legally liable for the interpretation or use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

The treatment dates covered by this authorization are from_____ to _____.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

DISCLOSURE

This information has been disclosed to you from records protected by State and Federal Laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. Information related to HIV/AIDS, alcohol and other drugs, and mental health and abuse issues are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated.

Approved by: _____ Date: _____ Released by:_____ Date: _____

Penn State is an affirmative action, equal opportunity university.

3000 Ivyside Park Altoona, PA 16601
Phone: 814-949-5540 Fax: 814-949-5731