

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Health Services University Telephone (570) 941-7667		Scranton, PA 18510-4507 Fax (570) 941-4298
T.	Roval#	DOB
I(print)	Royan	
hereby authorize Student Health Services at The Un		
[] release information to:		
[] request information from:		
Name:		
Address		
City/State/Zip Code		
The information will be used on my behalf for the fo	ollowing purp	ose(s):
By initialing the spaces below, I specifically authorize records exist:	ze the release	of the following medical records, if such
Medical records needed for continuity of care		Medical chart notes
Laboratory reports		Immunization Records
Pathology reports	_	Diagnostic Imaging reports
Other (specify)		
***	4.	
This authorization is limited to the following time pe	erioa:	be specific)
This authorization may be revoked at any time. Unle from the date of signing or shall remain in effect for	ess revoked e	arlier, this consent will expire 180 days
(Signature of patient.)	(D	ate)