# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION


**Student Health Center - Saint Joseph's University**
**Sourin Hall – 5600 City Avenue**
**Philadelphia, PA 19131**
**Telephone (610) 660-1175 Fax (610) 660-3378**


I ________________________________ SS No. ______________DOB___________
(Print)

hereby authorize Saint Joseph's University's Student Health Center to:

***( ) release information to:***

***( ) request information from:***

Name: ______________________________________________________________

Address: ____________________________________________________________

City/State/Zip Code: ____________________________________________________

Phone Number: ___________________________ Fax Number: ____________________

The information will be used on my behalf for the following purpose(s): _____________

______________________________________________________________________

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Medical records needed for continuity of care
_____ Laboratory reports
_____ Pathology reports
_____ Other ______________________________
(specify)

_____ Medical chart notes
_____ Immunization Records
_____ Diagnostic Imaging reports

____________________________________________________ ________________
*(Signature of patient/student)* *(Date)*