



## Authorization for Release of Personal Health Information

### Student Health Center

Linden Hall  
201 Mullica Hill Road  
Glassboro, NJ 08028-1701

856-256-4333  
856-256-4427 (fax)

\_\_\_\_\_  
CLIENT NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
ID # OR SOCIAL SECURITY NUMBER

This will authorize \_\_\_\_\_ to release confidential health information  
INDIVIDUAL NAME OR ORGANIZATION

to the following individual or organization: \_\_\_\_\_

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIPCODE

The specific type of information to be disclosed is \_\_\_\_\_

\_\_\_\_\_ and pertains to my treatment and/or service on or about: \_\_\_\_\_

The purpose for this disclosure is \_\_\_\_\_

I give authorization for the release of the above information for the purpose specified above. I further understand that I may revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain in effect for a period of \_\_\_\_\_ days, or 60 days if not specified.

I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign this form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by state and federal confidentiality rules.

\_\_\_\_\_  
SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO CLIENT

\_\_\_\_\_  
WITNESS SIGNATURE