Millersville University
SEIZE THE OPPORTUNITY

MU Health Services
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Millersville PA 17551-0302
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Phone: 717.871.5250
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO PARENT

M00_____

Patient Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____

I, the above named patient, do hereby authorize Millersville University Health Services, PO Box 1002, Millersville, PA 17551 to discuss/disclose my medical information to my parent(s)/family member listed below:

Name: _____ Relation: _____

Phone: _____

This authorization is provided for the release of:

□ All medical records

□ Records from (dates) _____ to _____

□ Records related to _____

□ Other (please specify) _____

In the event that these records contain protected information such as sexual health-related information (including HIV/AIDS/STI's), Mental Health records, Drug/Alcohol treatment records, and/or Sexual Abuse, I specifically:

□ Authorize release of any or all protected information

□ Authorize release of sexual health-related information ONLY

□ Authorize release of sexual abuse records ONLY

□ Authorize release of drug/alcohol treatment records ONLY

□ Authorize release of mental health records related to specific condition ONLY- list condition:_____

□ Do not authorize release of such information.

Disclosure: I understand that Millersville University Health Services (MUHS) will only discuss/disclose MUHS records, we will not forward other physician/facility medical records. I understand that I have the right to sign or not sign this form and that my treatment will not be affected by that decision. I understand that this authorization is in effect for one (1) year/twelve(12) months; however, I have the right to revoke this authorization at any time in writing to MUHS.

Patient Name (Print) _____ Date _____

Patient Signature _____ Witness Signature _____
Other than designated person above