Millersville University
HEALTH SERVICES

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40 Dilworth Road
Millersville, PA 17551
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E-MAIL: health.services@millersville.edu

Authorization for Release of Medical Records

Patient Name:_____ DOB: _____ MU ID: P_____

Address: _____ City: _____State:_____ Zip:_____

Phone:_____

I, the above-named patient, do hereby authorize:

- □ My medical records to be released **TO** Millersville University Health Services
- □ The release of my medical records (as specified below) **FROM** Millersville University to:

Name/Facility:_____

Address:_____

Phone:_____ Fax:_____

I request my records to be sent via: US Mail_____ Fax_____ *Email_____

* *Risk Warning Regarding Unencrypted Email Communication*
By checking e-mail as an option, you authorize your Protected Health Information (PHI), including medical records to be sent via unencrypted email. Please be aware that email is not a secure or confidential method of sending health records. Emails can be intercepted by unauthorized third parties, misdirected, or accessed by anyone with access to your email account or device. Health Services recommends records be shared through fax, mail, or picked up in person.

The information requested is:

- □ Records from (dates) _____ to _____
- □ All medical records
- □ Records related to _____
- □ Most recent physical examination and immunization records
- □ Other (please specify)_____

In the event 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 the release of such information
- □ Do not authorize the release of such information

Disclosure: 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. This authorization is in effect during the time I am a student at Millersville University; however, I have the right to revoke this authorization at any time in writing to MUHS.

Patient Name (Print) _____ Signature_____ Date _____