Millersville University
SEIZE THE OPPORTUNITY

MU Health Services
PO Box 1002
Millersville PA 17551-0302
www.millersville.edu

Phone: 717.871.5250
Fax: 717.871.7926

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

M00_____

Patient Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____

I, the above named patient, do hereby authorize:

□ My medical records (as specified below) ***TO*** Millersville University Health Services, PO Box 1002, Millersville, PA 17551 from:

□ Release of my medical records (as specified below) ***FROM*** Millersville University Health Services, PO Box 1002, Millersville, PA 17551 to:

Name/Facility: _____

Address: _____

_____

Phone: _____ or Fax: _____

I request that my records to be sent via: US Mail _____, Fax _____, I will pick up _____

The information requested is:

□ All medical records □ Records from (dates) _____ to _____

□ Records related to _____

□ Most recent physical examination and immunization records

□ 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 such information □ do not authorize release of such information.

I am requesting these records for the purpose of:

□ continued care □ personal request □ Other

Disclosure: I understand that Millersville University Health Services (MUHS) will only forward 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 am aware that this authorization is in effect for 6 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 _____