Millersville University
HEALTH SERVICES

Witmer Building
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Millersville, PA 17551
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Phone: 717.871.5250
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____DOB: _____ MU I.D# _____

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_____**By selecting the "Email" option I understand that Millersville University's email server does not have HIPAA compliant encryption to fully protect the confidentiality of medical records. Health Services recommends medical documents to be sent via US mail, fax 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 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

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): _____ Date: _____

Patient Signature: _____