Ursinus College

Authorization for Release of Medical Records

Student Name (PRINT):_____ Class Year: _____

Date of Birth ____/____/_____

Dates of Attendance/Service: ____/____/_____ to ____/____/_____

Address: _____

Phone: _____-_____-_____

I, the above named student, hereby authorize the Wellness Center at Ursinus College 601 E. Main Street, Collegeville, PA 19426 to:

- ☐ **Release Information to:**
- ☐ **Request information from:**

Name of Outside Person_____

Name of Agency/Institution/Office_____

Mailing address_____

Phone Number _____-_____-_____ FAX number _____-_____-_____

For Purpose of:

- ☐ Continued Care
- ☐ Employment
- ☐ Other_____
- ☐ Academic
- ☐ Insurance

Information Requested:

- ☐ All Medical Records
- ☐ X-rays
- ☐ Lab results
- ☐ Treatment Records

Signature_____ _____ Date: ____/___/_____