Ursinus College

Authorization for Verbal Communication

I, _____hereby authorize the Nurse Practitioner/Medical Doctor of the Wellness Center at Ursinus College 601 E. Main Street, Collegeville, PA 19426 to discuss/disclose my medical information to my parent(s)/ guardian/family members listed below:

Name: _____ Relationship: _____

Phone: _____/_____/_____

Disclosure:

- I understand that I have the right to sign or not sign this form and my treatment will not be affected by that decision.
- I understand that the Wellness Center at Ursinus College will only discuss my current medical information with the above person(s).
- I understand this authorization is in effect for 1 year (12 months).
- I understand that I have the right to revoke this authorization at any time by verbal or written request to the Wellness Center at Ursinus College.

Student Name (PRINT):_____ DATE:_____/_____/_____

Signature:_____