AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Health Center John Carroll University University Heights, OH 44118-4581
Telephone (216) 397-4349 Fax (216) 397-1787

I ____ DOB___________
(Print Student Name)
hereby authorize Student Health Center at John Carroll University to:

[ ] release information to: (e.g. parent/guardian-name below)

[ ] request information from:

Name:____

Address____

City/State/Zip Code____

The information will be used on my behalf for the following purpose (e.g. convey medical information)

____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:
_____Medical records needed for continuity of care _____Medical chart notes _____Laboratory reports

_____Immunization Records _____Pathology reports _____Diagnostic Imaging reports

_____Other_________________________________
(specify)

This release is valid for the remainder of my enrollment at John Carroll University unless revoked in writing.

Signed: ____ Date: ________________________________
(Student)
Witnessed: ____ Date: _______________________________
(Parent/Adult Witness)

I have decided to cancel the above authorization as of ____

Signed: ____ Date:________________________________