Shippensburg University • Etter Health Center
1871 Old Main Drive • Shippensburg, Pennsylvania 17257
(717) 477-1458 FAX (717) 477-4042
Todd V. Peterson, M.D., Medical Director

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, **authorize release of medical information**
Patient Name **PRINT**

_____
Date of Birth

_____
Requesters Telephone Number

Records From:

_____

_____

_____

Fax #: _____

Records To:

_____

_____

_____

Fax #: _____

Date of Treatment: _____

Records to Include:

_____ All Documentation
_____ Labs/X-ray
_____ Doctor / Nurse Notes
_____ Health Form
_____ Immunization Record

Include Disclosure of Records For:

	Yes	No
Drug/Alcohol Treatment	___	___
AIDS/HIV	___	___
Psychiatric/Mental Health	___	___

[If yes, include the Special Authorization Form]

GENERAL AUTHORIZATION: I understand and acknowledge that this general authorization allows the health care facility to release all or part of the records indicated above for the purpose stated. I understand that, on occasion, information may be released by telephone or fax.

This consent is valid for 90 days, unless revoked by me in writing before the release of the above designated information.

I read this form, or had it read to me and I understand it. I was given an opportunity to ask questions. Any question I asked was answered to my satisfaction. My signature below indicates my voluntary authorization for both the general and special release of information.

_____ _____ _____ _____
Signature of Patient *Date* *Signature of Witness* *Date*

****NOTICE****

Please allow 48 hours for processing a routine request. All emergency requests from your physician will be given the appropriate attention. Thank you for your cooperation in this matter.