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 TO PARENT(S) OR GUARDIAN

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

_____
Date of Birth

_____
Requesters Telephone Number

Records To:

Name _____
Address _____
Phone _____
Fax _____

Records From:

ETTER HEALTH CENTER
1871 Old Main Dr.
Shippensburg, PA 17257

Fax #: (717) 477-4042

Name _____
Address _____
Phone _____
Fax _____

Name _____
Address _____
Phone _____
Fax _____

Include Disclosure of Records For:

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

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

This consent is valid for academic year(s) ____-____, 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 the release of information.

_____ _____ _____ _____
Signature of Student *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.