



## AUTHORIZATION FOR DISCLOSURE OF HEALTH HISTORY INFORMATION

By completing the form below, you give permission to the AUD Health Center Director to disclose your medical records. You have the right to revoke this consent at any time by notifying the University Health Center in writing.

STUDENT I.D.

COMPLETE NAME

DATE OF BIRTH DD/MM/YY

GENDER

Female

Male

ADDRESS

( )

MOBILE

I authorize AUD Health Center to disclose information contained in my medical records to

NAME

ADDRESS

( )

MOBILE

PURPOSE FOR DISCLOSURE

I do not want the following information disclosed

PATIENT SIGNATURE

DATE mm/dd/yy

PERSON ASSISTING PATIENT WITH FORM COMPLETION

METHOD OF RELEASE

DATE OF RELEASE

**NOTICE TO STUDENTS:** All health information is confidential however the President, Executive Vice President, Dean of Student Services, and Housing Manager will have access to this information (as needed).