# Authorization for Disclosure of Health Information

By completing the form below, you give permission to AUD Health Center Director to disclose, or not, your medical records. You have the right to revoke this consent at any time by notifying the University Health Center in writing.

Name: ----------
Address: ----------
Date of Birth: ----------

ID Number: ----------
Telephone (Mobile): ----------
Gender: F M

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

2. I do not authorize AUD Health Center to disclose information contained in my medical records

Date: ----------

Student Signature: ----------

Date: ----------

Health Center Director Signature: ----------