TOWSON UNIVERSITY
Health Center at Ward and West
8000 York Road
Towson, MD 21252-0001
Phone: 410-704-2466
Fax: 410-704-3715
healthcenter@towson.edu

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization will expire automatically sixty days from the date signed. I understand that I may revoke this authorization at any time by writing to the Director at Towson University Health Center, but it will not affect any information previously sent.

PATIENT INFORMATION (Please Print)

Last Name	First Name	Middle Initial	TU ID #

Street Address	Birth Date

City	State	Zip Code	Phone Number

I REQUEST THAT TOWSON UNIVERSITY HEALTH CENTER:

(CHECK ONLY ONE)

☐ RELEASE MY RECORDS TO ☐ RECEIVE MY RECORDS FROM

Name			
Mailing Address			Phone Number
City	State	Zip Code	Fax Number

METHOD (Records cannot be emailed)	☐ PICK UP	☐ MAIL	☐ FAX
	Records must be picked up within 30 days of completion	Please note, after two unsuccessful attempts via mail/fax, you will be contacted to pick up your records within 30 days.	

RECORDS TO INCLUDE	DATE (IF APPLICABLE)	DO NOT INCLUDE	DATE (IF APPLICABLE)
☐ Full Medical Record **OR** ☐ History & Physical Exam ☐ Sexual Health/ GYN Records ☐ Immunizations/ PPD ☐ Laboratory Tests/ Radiology ☐ Other: _____		☐ HIV Related Information ☐ STI/ Communicable Disease Related Information ☐ Alcohol/Drug Abuse Related Information ☐ Mental Health Diagnosis/ Treatment Information	

PURPOSE OF DISCLOSURE OF INFORMATION	☐ At Patient's Request ☐ School/ Employment ☐ Continuity of Care ☐ Other: _____

I understand that the Health Center may not condition its provision of treatment on my signing this authorization, with the following two exceptions:

1. If I refuse to authorize disclosure for research purposes, Health Center may refuse to provide treatment related to that research.
2. If I refuse to authorize disclosure to a third party, Health Center may refuse to provide health care that is solely for the purpose of disclosure to that third party (e.g. physical exam to Nursing or Athletic Department).

I understand that I may revoke this authorization at any time, by writing to the Director at Towson University Health Center. The revocation will become effective on the day the University receives it, except to the extent that: (a) the University has made a disclosure before the effective date of the revocation; or (b) if the authorization was obtained as a condition of obtaining health insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Charges may apply for requested records.

METHOD OF NOTIFICATION	☐ Records Given to Patient at Time of Request ☐ Email Confirmation of Request Completion to: _____ @ _____. _____

PLEASE NOTE: ALLOW 3-5 BUSINESS DAYS FOR COMPLETION OF REQUEST

Signature	Date

OFFICE USE ONLY

Received in office by: _____ Date: _____

Completed by: _____ Date: _____

Pick up verification: ☐ Not Applicable
Staff Member: _____ Date: _____
ID Type: ☐ OneCard ☐ License/ Government ID ☐ Other: _____

Pick up signature: _____