TEMPLE UNIVERSITY
A Commonwealth University

Student Health Services
1700 N. Broad Street, 4th floor
Philadelphia, PA 19121
Tel: (215) 204-7500
Fax: (215) 204-4660
medicalrecords@temple.edu

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM STUDENT HEALTH SERVICES

I, _____, hereby authorize
(Name) (Temple ID#) (DOB)
Temple University Student Health Services

☐To release information to: ☐ To exchange information with:

Name-(health facility, physician, other institution, etc.... .)			
Street Address	City	State	Zip
Phone #	Fax #		

Requests for medical records take 7-10 business days to process. Fees may apply.

SPECIFIC INFORMATION TO BE RELEASED—CHECK EACH CATEGORY THAT YOU WANT RELEASED

___Immunizations and/or Tuberculosis Testing
___Lab test results (please specify which tests)_____
___Most recent physical examination
___Imaging reports (please specify which: ultrasound, X-ray, MRI, etc.)_____
___Medical records regarding a specific condition:_____
___Medical records from a specific time period PLEASE SPECIFY DATE RANGE: _____
___Most Recent Annual GYN Progress Notes/Records **AND** Pap Cytology/Colposcopy results

I understand that any information disclosed in response to this request will NOT include information related to my treatment for HIV/AIDS, mental health, alcohol and/or substance abuse UNLESS I specify below:

☐ Information about my HIV status _____
☐ Information about my mental health_____
☐ Information about alcohol and/or substance abuse_____
☐ All Records (**This could include information about my sexual activity and sexually transmitted diseases**) _____

INITIAL EACH ITEM THAT YOU WANT INCLUDED IN THIS REQUEST

EXPIRATION DATE: _____
Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time

I understand that my records are protected under the Federal Privacy Act PL 93-575, the Federal Alcohol and Drug Abuse Act PL 92-282, the Pennsylvania Mental Health Procedures Act, 1976, and the Pennsylvania Confidentiality of HIV-Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to this office and/or my consent automatically expires under the circumstances previously described.

_____ _____
(Signature) (Today's Date)

Best Number to Reach You: _____

☐ DOB Or TUID Verified _____
☐ Records Mailed _____ ☐ Records Emailed _____ ☐ Records Faxed _____