

**KUTZTOWN UNIVERSITY HEALTH & WELLNESS CENTER**  
**CONSENT TO RELEASE INFORMATION**  
**Fax 484-646-4159 / 610-683-4635**  
**Phone 610-683-4082 - PO Box 730, Kutztown, PA 19530**

\_\_\_\_\_  
Patient's Full Name (Please Print)                      /                      /                      \_\_\_\_\_  
Date of Birth                      KU ID                      \_\_\_\_\_  
Cell Number

I authorize Kutztown University Health & Wellness Services to DISCLOSE information in my medical record to:

Name \_\_\_\_\_ Organization/Agency: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**1. TYPE OF INFORMATION TO BE DISCLOSED:**     Counseling     Case Management     Medical

GYN     Other \_\_\_\_\_

**2. PURPOSE FOR DISCLOSURE:**  Continuation of Care     Payment of Claim     Other \_\_\_\_\_

**3. EXTENT OF INFORMATION TO BE SENT:**  All Dates of Treatment     Date or Date Range \_\_\_\_\_

**4. DOCUMENTATION TO BE DISCLOSED:**  Treatment Notes     GYN Information     Lab Reports

X-Ray Report     Immunizations / PPD (TB)     Summary of Treatment (Counseling)

Other \_\_\_\_\_

I understand my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing:

\_\_\_\_\_ Alcohol/Drug abuse or dependency    \_\_\_\_\_ Mental Health    \_\_\_\_\_ HIV and/or AIDS    \_\_\_\_\_ Sexual Assault

I understand this release is valid for 90 days or \_\_\_\_\_ days (not to exceed 120 days) from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need n. sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Health & Wellness Center. The staff of the Health & Wellness Center cannot be held legally liable for the interpretation of use by person/persons to whom they are released.

**I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.**

\_\_\_\_\_  
Signature of Patient                      or                      Legal Representative/Relationship                      \_\_\_\_\_  
Date

**DISCLOSURE**

This information has been disclosed to you from records protected by state and federal laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. Information related HIV/AIDS, alcohol and other drugs, and mental health and abuse issues are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.