Marywood University, Student Health Services
Loughran Hall
2300 Adams Ave.
Scranton, PA 18509
Phone: 570-348-6249 Fax: 570-961-4735

***** Medical records will only be e-mailed directly to you. *****
All e-mails will be sent to your Marywood E-Mail Account unless you are a non-matriculating student.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Print and complete all highlighted areas.

Patient Name: Date of Birth:

Home Address: **Resident Students Also Provide** Room # & Dorm:

City: State: Zip Code:

Telephone: Graduated- Month/Year:

E-mail to: ***Only Immunization Records will be e-mailed; all other information will be mailed to the above address or can be picked up.***

Marywood E-Mail Address: ______________________________

Personal E-Mail: ***only for non-matriculating students:***

I hereby authorize Marywood University Student Health Services to release the following information.

Check appropriate line:

☐ My latest Health History and Physical

☐ Diagnostic test only
Type(s) ______________________________
Date(**s** ______________________________

☐ Immunizations/PPD Results & associated chest X-ray/Titers

☐ Other: ______________________________

Reason for disclosure (Check One)

_______Patient Request _______Follow up care _______Employment _______Transferring _______Insurance Reasons

_______Other ______________________________

- I understand that this request for release of information stands effective for 120 days or until _______________. I may revoke this Authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to: Marywood University Student Health Services, Loughran Hall, 2300 Adams Ave. Scranton, PA 18509. My revocation will be effective upon receipt, but will not be effective to the extent that Marywood University Student Health Services has taken action in reliance upon this Authorization.
- Disclosure of specific information authorized for release is limited to the above-mentioned recipient only.
- I understand that treatment, payment, enrollment or eligibility for benefits at Marywood University Student Health Services cannot be conditioned on the signing of this authorization.
- I also understand that once released, Marywood University Student Health Services has no control over any disclosure of my records that may occur, and my information may be subject to redisclosure by the recipient and no longer protected.

Signature: Date: Time:

Print Name:

If not signed by the patient, indicate your relationship/authority to sign for the patient: ______________________________

---------------------------------- To be completed by Student Health Services Only -------------------------------

Records were E-Mailed, Mailed, Received On: _________________ ______________________________
Date Signature