

MILLERSVILLE UNIVERSITY
WITMER HEALTH SERVICES, P.O. 1002, MILLERSVILLE, PA 17551-0302
717-872-3250, FAX 717-871-2243

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: NAME/FACILITY: _____

ADDRESS: _____

To release to: NAME/FACILITY: _____

ADDRESS: _____

Any and all information regarding my physical condition and treatment rendered, and if necessary, to allow them or any physician appointed by them to examine any x-ray pictures taken of me regarding my physical condition or treatment. I authorize release of this information to the above individuals for the purpose of continuing care, and allow them, or any other physicians appointed by them, to examine this information.

_____ This authorization includes the release of psychiatric/psychotherapy records.

_____ This authorization includes the release of sexual abuse records.

_____ This authorization includes the release of drug/alcohol treatment records.

_____ This authorization includes the release of AIDS/HIV medical records.

_____ This authorization includes release of medical records to the Human Resources representative in the event of a work related injury or campus injury.

_____ This authorization includes release of medical information to Omega Laboratories or Lancaster Regional Medical Center laboratory/ER in the event of laboratory testing/or emergency.

_____ This authorization includes the release of medical information to the trainers at Millersville University in the event of a sports related injury medical problem.

Signature _____ Date _____

Printed Name _____

Birth date _____ SS# _____

Address _____

Information requested _____

I understand and agree that the information released will cover my entire student career at Millersville University and I may change it at any time by completing a new Request for Release of Medical Records form, at which time any prior forms signed by me will become null and void.