Immaculata University Student Health Services

PURPOSE FOR THIS REQUEST: (Check one.)

☐ Healthcare  ☐ Insurance coverage  ☐ Personal  ☐ Transfer of Care  ☐ Other

TYPE OF RECORDS REQUESTED: (Check one.)

☐ Immunization history
☐ All medical records related to a specific illness or injury.

Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Specific information (Select one or more, as applicable)
  ☐ Procedure report  ☐ History & physical  ☐ Physical Therapy  ☐ Laboratory test results
  ☐ X-ray reports  ☐ Other _______________________________________________________

(Please describe.)

☐ Copy of the entire medical record, as allowed by law.

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.
☐ One year from the date of this authorization OR ________________________ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request and for medical records of any future treatment of the type described above until: ________________________

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

I, __________________________ (print name) authorize Student Health Services to release/disclose copies of information for services provided.

Signature of Patient or Representative________________________________________ Date________________________

Relationship to Patient (if requester is not the patient) _____________________________________________

Please mail or fax to:
IU Health Services
PO Box 638, 1145 King Road, Immaculata PA 19345
Fax: 484-323-3513