Health Services

Authorization for Release of Patient Information

Whittier College
Student Health Services
13612 Philadelphia Street
Whittier, CA 90608
Phone: (562) 464-4548
Fax: (562) 464-4511

Patient Name _____ **Date** _____
Date of Birth _____ **Student ID #** _____

Address_____

Cell Number _____

I request and authorize Whittier College Student & Wellness Center

Address: 13612 Philadelphia Street, Whittier, CA 90608

Phone: (562) 464-4548 Fax: (562) 464-4511

To release health care information of the patient named above to:

Name: _____

Address: _____

Phone #: _____ Fax: _____

Information to be Released

- ☐ Physical Exam
- ☐ PAP Smear Results
- ☐ Labs, please specify which test(s): _____
- ☐ Radiographic view, please specify: _____
- ☐ TB Skin Test
- ☐ Specific Vaccine(s), please list: _____
- ☐ All Vaccination Records
- ☐ Other: _____

Purpose of Disclosure

- ☐ Changing Physicians
- ☐ Provider Needs this for Continuity of Care
- ☐ Second Opinion
- ☐ Insurance Purposes
- ☐ Another College Needs This
- ☐ Other_____

Continued on Reverse Side

I authorize the release of these records as indicated and certify that I am the patient or parent/legal guardian of the patient above. I understand that there may be sensitive information within these records regarding my health. By signing below I acknowledge that I have read and understand this authorization.

Signature of Patient _____ Date: _____

OR

Signature of Parent/Legal Guardian of Authorized Person_____ Date:_____

For Office Use Only

Initials of Office Personnel Taking Information: _____

Date Request Filled

- ☐ **Faxed** **Date: _____**
- ☐ **Mailed** **Date:_____**
- ☐ **Picked up in person** **Date: _____**

Fee Collected **Date:_____**
Method of Payment **_____**