

Consent to Release Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

SSN or Xavier Student ID No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

I hereby authorize the McGrath Health and Counseling Center, Xavier University, 3800 Victory Parkway, Cincinnati, Ohio 45207 to release copies of medical records or counseling information including but not limited to information concerning drug abuse or drug related conditions, alcoholism, psychological, and psychiatric conditions, HIV testing, AIDS diagnosis, AIDS-related conditions, provided that such release is limited specifically to material of the nature and extent described herein:

Specific information requested:

Counseling records:

- Case summary, Psychological testing reports, Diagnosis(es), Medications and dosages, Drug/Alcohol Information

Medical records:

- X-Rays, Lab Results, History & Physical, Progress notes, Complete health record, Dates of treatment, Drug/Alcohol Information, Immunizations, Other:

Information to be released to : \_\_\_\_\_

Purpose of release of information: \_\_\_\_\_

I understand this information is being released from records the confidentiality of which may be protected by law and that this information will not be re-disclosed.

This consent to disclose may be revoked by me at any time by written notice except to the extent that action has been taken thereon. This consent will expire in ninety days after the date below.

I acknowledge that I have read and fully understand this authorization.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Other Legally Authorized Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_