McGrath Health and Wellness Center
3800 Victory Parkway, Cincinnati, Ohio 45207-7611
Ph: (513) 745-3022 Fax (513) 745-3563

**Consent to Release Information to the Health and Wellness Center**

Name _____ Today's Date _____

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

I hereby authorize _____

_____

_____

to release copies of medical records and other information to the McGrath Health and Wellness Center, Xavier University, 3800 Victory Parkway, Cincinnati, Ohio 45207 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:

Dates of treatment: _____

Specific information requested:

____ Case summary
____ Diagnosis(es)
____ Types of service
____ Psychological testing reports
____ Medications and dosages
____ Other: _____

**Medical records:**

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

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 redisclosed without my written consent.

This consent 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, or sooner, in which case this authorization will expire on _____.

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

_____ _____
Signature of Patient Date

_____ _____