POINT PARK UNIVERSITY

Student Health Center
3RD Floor Student Center
Phone 412-392-3800 • Email studenthealth@pointpark.edu

Authorization to Disclose Medical Information

Student Name: _____ DOB:_____ID#:_____

I give permission to disclose medical information (including information such as, but not limited to: date/time of visits, chief complaint, assessment details, plan of treatment) from my Point Park University Student Health Center chart to the following individual (s):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Student's Signature: _____ Date:_____