Student Health Center

3RD Floor Student Center

Phone 412-392-3800 • Fax 412-392-3801

Authorization to Disclose Medical Information

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 #: ___________

*If this is a request for immunization records to be mailed to another educational institution, please provide their mailing information below:

Name of School: ____

Mailing Address: ____

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Student's Signature: ______________________________________ Date:_____________

REV 2/22