Student Health Center

3RD Floor Student Center

Phone 412-392-3800 • Fax 412-392-3801

Authorization to Release Medical Documentation

I, _____ herby authorize Point Park University Student Health Center to

□ release and/ or □ obtain confidential information from:

Person or Facility: _____

Address: _____ Phone: _____

This may include but is not limited to documented information such as immunization records, date/time of visits, medical history and evaluation, assessment details, plan of treatment, doctor appointments, transport to other medical facilities.

For the following purposes:

- Continuity of care
- Coordination of care
- Proof of immunization
- Other (please specify): _____

This consent will expire automatically one year from the date on which it was signed.

Student Signature: _____ Date: _____