Widener University

Student Health Services – One University Place, Chester PA 19013

Release from WU - Medical Records Release Form

Name (print) _____ Maiden or other name (if applicable) _____

Home Street Address: _____ City, State, Zip: _____

Cell Phone: _____ University ID#: _____

Date of Birth: ____ / ____ / _____ Todays Date: ____ / ____/ _____

Please check your status:

Current student _____

Former Student _____ Year graduated _____

Withdrawal/Leave of Absence _____ Year _____

I (print Name) _____ authorize Widener University SHS to release my

(be specific) _____ records from the year _____ through _____.

I DO NOT GIVE PERMISSION FOR THE FOLLOWING INFORMATION TO BE DISCLOSED: (As defined by applicable state and federal laws. **Please check and initial**)

HIV _____ Mental Health _____ Alcohol/Drug treatment _____

Expiration: This authorization is good until the following date/event: _____
Note: If this item is left blank, authorization will expire in one year from the date signed.

I request that my records be:

Mailed to my home address _____ Held at SHS for pick up _____ Sent as a Secure Message _____

___ Faxed to: _____ Fax # _____ Phone # _____

___ Mailed to: _____

Address _____ City, State, ZIP _____

I understand that I have no obligation to disclose this information from my record and that I may revoke this consent at any time by notifying Student Health Services in writing. I also understand that my signing or revoking this authorization will not affect my health care treatment or coverage under any health plan.

_____ _____ ____ / ____ / _____

Student Signature Witness Date