

Authorization to Disclose Health Care Information

Waldorf College
Student Health Services
Forest City, Iowa 50436
Phone: 641-585-8157
Fax: 641-585-8194

Patient Information:

Patient Name (please print): _____

Former Name (if any): _____ Birth Date: _____

Address: _____

Phone # () _____ Cell Phone # () _____ e-mail _____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release Information From:

Send My Information To:

Method for sending information (circle one): Mail Fax Date Needed: _____

Reason for Release (circle one):

To update my regular doctor (provider)

I am moving / transferring to another college

Information needed for job

Other: _____

I Understand That:

- This authorization will automatically expire one year from the date of my signature or on ___ / ___ / ___ .
- The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.

Signature of patient or legal guardian (patients over 18
must sign own release)

Date