



**YORK COLLEGE**  
OF PENNSYLVANIA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_ (Name), give full permission to The York College of Pennsylvania Health Center at York College of Pennsylvania York, Pa. 17405-7199

To release the following information to:  
TO:

INFORMATION REQUESTED:

- |                                  |                                    |
|----------------------------------|------------------------------------|
| _____ COMPLETE MEDICAL RECORD    | _____ DISCHARGE SUMMARY            |
| _____ OFFICE/PROGRESS NOTES      | _____ FOLLOW-UP RECOMMENDATIONS    |
| _____ DIAGNOSIS                  | _____ MEDICAL HISTORY              |
| _____ CARDIAC/EKG REPORTS        | _____ CURRENT MEDICATIONS          |
| _____ TREATMENT PLAN             | _____ IMMUNIZATIONS                |
| _____ XRAY; IMAGING REPORTS      | _____ RECORDS FROM OTHER PROVIDERS |
| _____ HISTORY AND PHYSICAL EXAMS | _____ LABORATORY REPORTS           |
| _____ CONSULTATIONS              | _____ OTHER                        |

THE PURPOSE OR NEED FOR SUCH DISCLOSURE:

- \_\_\_\_\_ To aid in continuing care  
 \_\_\_\_\_ For the purpose of administrative/academic planning  
 \_\_\_\_\_ Other: \_\_\_\_\_

I understand that these records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent. I also understand that I can revoke this consent at any time in writing, except to the extent that the person who is to make the disclosure or the person receiving the information has already acted upon it. I understand that this consent expires automatically as described below. I understand that I may request further explanation of this form at any time. I understand that I can receive a copy of this form upon my request.

I understand the content of this form as it has been explained to me.

The authorization of this form is valid until \_\_\_\_\_ unless revoked in writing prior to the expiration date. This authorization and request is fully understood and voluntary on my part.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_

Address and Telephone Number \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_