Winslow Health Center - Allegheny College
Authorization for Release of Health Care Information
Instructions

Requests will be completed within 30 days from confirmation of receipt of request. In pursuant to PA Code 563.6., we are required to keep records for seven years, however, WHC's current policy is to maintain alumni health records for ten years post graduation or withdrawal from Allegheny (subject to change without notice).

1. Print Name - clearly print your last name, then your first name
2. Allegheny ID# - your ID should be 7 digits long; alumni ID number is the same as when you were a student and is associated with you forever; if your starts with 0s and has more than 7 digits take the extra 0s out -- if yours has less than 7 digits, add 0s to the beginning to make it 7 digits long
3. Social Security # - required if you are requesting your records sent to an outside medical provider
4. Date of Birth - please use DD/MM/YYYY format
5. Phone # - please include a phone number that we can contact you at if we have questions; circle the appropriate type
6. Disclosure authorization selection - select "self" if you want the record sent only to you, select the second option for any other organization or individual and give their full address, phone number, and fax number if you want it sent via fax
7. Record to Be Disclosed - specify the dates (year only is okay) of the information you want released and check all the information options you want included (make sure you read them carefully and select *only* the ones you want)
8. Purpose for Disclosure - why you want the information released (for example: employment, to establish a new primary care provider…)
9. Student Signature - current or former student signature and date; <u>required</u>
10. Witness Signature - someone other than yourself to witness your signature; <u>required</u>

Completed authorization form can be...

– Mailed to: Winslow Health Center, 520 N Main St, Box 26, Meadville, PA 16335

– Faxed to: (814) 336-3050

– Emailed to: whc@allegheny.edu

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

WINSLOW HEALTH CENTER - ALLEGHENY COLLEGE
520 NORTH MAIN STREET – BOX 26, MEADVILLE, PA 16335
PHONE: (814) 332-4355 FAX: (814) 336-3050
please read instructions carefully and in full

_____ _____ _____ _____
Print Name (Last, First) Allegheny ID# Soc. Sec. # Date of Birth

_____
Address City State Zip

_____
Phone (circle one) Mobile Home Work

I authorize Winslow Health Services to disclose information contained in my medical record:
[ ] Self

[ ] _____
Name / Organization

_____
Address City State Zip

_____
Phone Fax

RECORD TO BE DISCLOSED:
Date of treatment from _____ to _____

Check all that apply (ONLY SELECT THE INFORMATION YOU WANT INCLUDED):
__Clinical Treatment Notes, __Lab Reports, __Radiology Reports, __Immunization Information, __HIV Related Information, __Sexual Assault Information, __Substance Abuse Information, __Psychological Related Information, __Other _____

PURPOSE FOR DISCLOSURE:_____
_____
_____
_____

I understand that I have no obligation whatsoever to disclose any information from my record, and I understand that I may revoke this consent at any time by notifying Winslow Health Center in writing and/or specifying a date, time, event, or condition upon which my consent will expire without revocation. I have read this form and have had it explained to me and I understand its content. Consent expires 90 days from the date of signature unless otherwise noted.

_____
Student Signature (*required*) Date

_____
Witness Signature (*required*) Date

Requests will be completed within 30 days of receipt in accordance with Pennsylvania State Law.
http://patientsafety.pa.gov/NewsAndInformation/Brochures/Documents/brochure_medical_records.pdf
https://www.healthit.gov/how-to-get-your-health-record/get-it/#how-long-will-i-have-to-wait