Cornerstone
UNIVERSITY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name _____ Date of Birth _____
Last First M/I

Address _____City/State/Zip _____

I Authorize the Release of Protected Health Information to the Following People:

Name	Relationship	Phone Number

Information to be Released:

☐ **Entire Record or**
☐ Immunization Records ☐ Treatment Notes ☐ Required Health Forms ☐ Consultation Reports
☐ Other:_____

This authorization will automatically expire:

☐ ___/___/___ (may not exceed 12 months from the date of signature below) **or**
☐ When I Graduate or Withdrawal from Cornerstone University.

Student Must Read:

I have the right to revoke this authorization at any time; if I revoke this authorization, I must do so in writing and present it dated and signed to the Cornerstone Health Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand authorizing the use or disclosure of the information identified above is voluntary.

Signature: _____Date:_____
(Patient / Legal Representative)

Printed Name: _____