

North Park University Health Services
3317 W. Foster Ave., Chicago, IL 60625
Phone (773) 244-4897, Fax (773) 244-4888

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that I may revoke this authorization at any time by presenting my written revocation to North Park University. I also understand that revocation will not apply to information that has already been released in response to this authorization.

I authorize: _____ North Park University Health Services *OR* Other: _____

To use or disclose to: Name & Address: _____

Phone and/or Fax: _____

The protected Health Information of:

Student Name: _____ Student ID Number _____

Date of Birth: _____ Address: _____

Specific description of information to be disclosed, including date(s). Please initial to indicate information requested.

Initials	Information to be Disclosed	Dates (from/to)
	Clinic Notes	
	Immunizations	
	Lab Reports	
	Pathology Reports	
	X-Ray Reports	
	Consultation(s)	
	Other (please specify)	

The purpose of the disclosure is: _____

I understand that I may refuse to sign this authorization.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire automatically 90 days from the signature.

I have read and understand the information in the Authorization form. If I have any question about disclosure of my protected health information, I may contact Jennifer Furey, Director of Health Services.

Signature of Student: _____ Printed Name: _____

Date: _____