



Valparaiso University

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Health Center
1406 Laporte Avenue
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Authorization for Release of Medical Information

I hereby authorize Valparaiso University Health Center staff to release information to the following person(s):

Three horizontal lines for entering the name and address of the requestor.

(Name and address of requestor)

To review or receive a copy of my medical records pertaining to:

- Immunization Records Only
Specific Office Visit
Give Date
Labs and/or X-Rays
All Medical Records

The information being released is for the following purposes:

Horizontal line for listing purposes of release.

This authorization shall remain valid through the current academic school year or until the following date:

I understand that I may revoke this authorization to release medical records to the above named person(s) in writing at any time. I also understand that unless I indicate otherwise, this authorization to release medical records includes permission to release information pertaining to my physical illness ONLY. I understand that my records are protected under federal and state confidentiality laws and cannot be disclosed without my written consent.

Print Name Date of Birth

Patient's Signature Date