THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Student Health Services, 800 Linden Street, Scranton, PA 18510-4507
Phone: (570) 941-7667 • Fax: (570) 941-4298

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Student Instructions: If you have a recent physical on file at your former institution, please complete this Authorization, sign it and send it to your former health center for release of the appropriate information.

I, ____ Date of Birth _____________
(Print)

hereby authorize ____
(Name of college/university holding student medical records)

to release to: Student Health Services
The University of Scranton
800 Linden Street
Scranton, PA 18510-4507

the following medical records, if such records exist:
_____ Medical History
_____ Immunizations
_____ Physical Exam
_____ Medical records needed for continuity of care

Reason for request:
_____ Transfer student to The University of Scranton

Please release these records within two weeks of receipt of this authorization.

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

______________________________________ ___________________________
(Signature of Student) (Date)

Rev. 4/2017

Please submit this form to your former institution by August 1.