



Student Authorization for Release of Health Information

Mailing Address:

Grace College Student Health Center
200 Seminary Drive
Winona Lake, IN 46590

Phone: 574.372.5100, Ext. 6472

Fax: 574.372.5116

Email: HealthCenter@Grace.edu

Student Name: _____

Alternate/Maiden Name: _____

Date of Birth: _____

Student ID#: _____

You are welcome to complete and submit multiple forms, limiting the information made available to different individuals. If the information to be released is the same, feel free to include multiple individuals on one form.

WHAT TO RELEASE - I authorize the release of the following information (mark all that apply):

- All health/medical information
- Any pertinent health/medical information for the following time period, from _____ to _____
- Any pertinent health/medical information for the following incident (please be specific)

Other _____

RELEASE TO WHOM – The selected information may be released to all of the following people and/or college offices:

- Self
- The following family members/guardians/spouse _____
- Disability Services Coordinator
- Grace Student Affairs (Specify, such as Dean of Students or Chapel, RD, Counselor) _____
- Grace Athletic Department and/or Athletic Trainers
- Medical Provider (Physician Name and/or Clinic Name) _____
- Grace Coaching personnel
- Other (Name & Relationship) _____

HOW TO RELEASE – Please mark the desired means of release and if applicable include the fax number or address.

Although you may email a scan or picture of this authorization form, we cannot release the health records by email.

- | | |
|--|---|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Pick up at the Health Center |
| <input type="checkbox"/> Mail records to _____ | <input type="checkbox"/> Fax records to _____ |

Mark Expiration of Authorization: One year from signature (maximum) Other date (specify) _____

Except to the extent that action already has been taken, at any time this consent may be revoked by you in writing.

Student Signature _____ **Date** _____

Witness Signature _____ **Date** _____