Wellness Center at Winans Hall
201 Mullica Hill Road ♦ Glassboro, NJ 08028
Phone: (856) 256-4333 ♦ Fax: (856) 256-4427

Rowan University

Authorization for Release of Confidential Information

1. I hereby give permission to Rowan University Wellness Center, Winans Hall, 201 Mullica Hill Road, Glassboro, NJ 08028 to disclose the health information of:
   Patient/Client _____
   Date of Birth _____ Banner ID _____
   Address _____
   Email _____ Cell Phone _____
2. The Wellness Center is to: release, obtain, or discuss health information:
   - ☐ Release of information to
   - ☐ Obtain information from
   - ☐ Discuss information on an ongoing basis with
3. Person or organization information/records are to be released to or obtained from:
   Name _____
   Address _____
   Telephone_____ Fax _____
4. Reason for release/disclosure of confidential records:
   - ☐ Further Health Care
   - ☐ Legal Investigation
   - ☐ Personal Use
   - ☐ Verification of Attendance
   - ☐ Academic Accommodations
   - ☐ Further Mental Health Evaluation/Treatment
5. Information to be disclosed. *(Please check all appropriate sections of the health record to be released)*
   - ☐ Records Only Related to the Following Date(s) of Service _____
   - ☐ Attendance Confirmation of the Following Date(s) _____
   - ☐ Medical Clinic Notes
   - ☐ All
   - ☐ Exclude Behavioral Health Consults
   - ☐ Medical Clinic Notes – Excluding Mental Health Screens and Behavioral Health Consults
   - ☐ Consultant Reports
   - ☐ Immunizations
   - ☐ Lab/Pathology Reports
   - ☐ Psychotherapy Notes
   - ☐ Intake Evaluation/Assessment
   - ☐ Termination/Transfer Summary
   - ☐ Psychiatric Evaluation
   - ☐ Psychological Evaluation
   - ☐ Alcohol/Drug Information – Written Summary
   - ☐ Evaluation/Treatment/Treatment Planning – Written Summary
   - ☐ Verbal Summary Information
   - ☐ Other: _____
6. Special instructions about information released:
   _____

I give my authorization for the release of the above information for the purpose specified above. I further understand that I may revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain in effect for a period of _____ days, or 60 days if not specified. Requests will be processed within 5-7 business days.

I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed in accordance with Rowan University Patient Rights and Privacy Policy. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by state and federal confidentiality rules.

_____ _____
Client/Patient Signature Date Legal Representative/Guardian Date

_____ _____
Witness Signature Date Legal Representative relationship to client Date

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For Office Use Only *(Verify photo ID if request made in person)*

☐ Record was faxed/mailed on: Date/Time: _____

☐ Record given to student on: Date/Time: _____

☐ No records. Student notified on: Date/Time: _____