Consent for the Release of Confidential Information

I, _____ Date of Birth_____

Authorize Cabrini University Health Services to disclose Health Information:

To:

_____

(Name of Person & Relationship)

_____

(Email & Phone Number)

The following information: (Check all that apply)

☐ Immunizations ☐ Medical History Forms ☐ Medical Visit Information

☐ Lab results ☐ STI/STD ☐ Other_____

I understand that my records are confidential and cannot be disclosed without my written consent unless required by law. I also understand That I may revoke this consent at any time except to the extent that action has already been taken. I understand that this request may take up to 7 days to be completed.

Please email the form to: healthservices@cabrini.edu

Name_____ Date_____
(Authorization Expires 1 Year from Date of Authorization.)

Staff Signature and Date Received_____

Contact Health Services at 610-902-8400 or via email at healthservices@cabrini.edu with questions or concerns.