**Wellness Center**

# *Permission for Release of Information*

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), the Wellness Center at Aurora University requires your written consent before disclosing any personal health information. Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated and signed.

I, ______________________________________________________________________

Print Name

______________ ( *** / ** / ________) , do hereby request that _________________________________

Date of Birth    last 4 digits SS# (required)    Name of Institution

**Have you previously attended AU: No Yes**

(If so, please list last year attended: _______________ and Student ID#: _________________________)

**Release the following information from my health record**: *(Please check all that apply)*

______ Immunization Records

______ Care delivered on this specific date only ____ / ____ / ____

______ Other: ____________________________________________

**This information is to be released to:** *(Please indicate)*

Aurora University
Wellness Center
347 S. Gladstone Ave.
Aurora, IL 60506
Phone: (630) 844-5434
Fax: (630) 844-5611

Or to:

_______________________________________
Name
_______________________________________
Address
_______________________________________
City/State/Zip
_______________________________________
Telephone Number
_______________________________________
Fax Number

____________________________________________________________ ____________________

Student's Signature    Date

*IMPORTANT: As of June 1, 2016, only one immunization record request honored per student. Recommend records be released to yourself to make copies to distribute accordingly.*

*****Please allow 5-7 working days for processing of request*****

Rev. 5.2016