GWYNEDD MERCY UNIVERSITY

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _________________________________Date of Birth_____________________

Authorize the Gwynedd Mercy University Health &Wellness Center located at:

To disclose to:

____

(Name of Person & Organization)

____

(Address)

____

(Phone Number **and** Fax Number)

The following information: ____ Immunizations ____PPD test (tuberculosis) ____ lab results

____ Medical history form ____ Other __________________________ (Check all that apply)

____

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 business days to be completed.

Please email the form or mail to: Donna Ferguson
Gwynedd Mercy University
Health & Wellness Center
1325 Sumneytown Pike
Gwynedd Valley, PA 19437
ferguson.d@gmercyu.edu

Name ____ Date ______________________

Staff Signature and Date Received____