



AURORA UNIVERSITY

Wellness Center

630-844-5434 • 630-844-5611 (fax)

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 Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated and signed.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

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

- _____ Immunization Records
- _____ Physical Exam
- _____ 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

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