



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 Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated and signed.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