



Student Health Service
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Authorization For Release of Information

I. Name: _____ Address: _____

DOB _____ Phone _____

II. Information Released FROM: _____ Information Released TO: _____

*Information in your chart that was not originally generated by Luther College Health Services will not be released to another facility. Such information must be obtained from the original source.

- III. The information to be released is:
- Entrance Physical Exam
 - Mental Health Treatment
 - Chemical Dependency/ Drug Or Alcohol Abuse Treatment
 - Pathology Reports
 - STD Testing
 - X-ray Reports
 - Immunizations Only
 - Lab
 - Drug Screen Result
 - EKG / EEG Reports
 - Progress Notes
 - Other _____

IV. Dates of Information to be Released:
From: _____ To: _____

- V. Reason for Release:
- Referred by Dr. _____
 - Moved
 - Changing Clinics
 - Other _____

VI. I am personally responsible for the above named records.

VII. Signature _____ Date _____
Social Security # _____ Luther ID # _____

For Office Use Only _____

Information was sent via: Patient Fax Mail By: _____ Date: _____