OAKWOOD UNIVERSITY

HEALTH AND COUNSELING SERVICES
Cunningham Hall 7000 Adventist Blvd. Huntsville, AL 35896
Phone: (256) 726-7840 Fax: (256) 726-7471 Email: ouhs@oakwood.edu

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Student ID#:_____

Previous Name: _____Date of Birth: _____ Phone Number(s): _____

I request and authorize the release of my health information as specified below:

FROM Name: ___Oakwood University Health Services_____

Address: ___7000 Adventist Blvd._____

City: ___Huntsville_____ State: ___AL___Zip Code: __35816_____

Phone: ____(256) 726-7840_____ Fax: ___(256) 726-7471_____

To Name: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____ Fax: _____

This request and authorization apply to:

- ☐ Immunization Records Only _____ Email or Fax _____
- ☐ Health Care information relating to the following treatment, condition, or dates: _____
- ☐ All health care information
- ☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

Yes___ No ___ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes___ No___ I authorize the release of any records regarding drug, alcohol or mental health treatment to the individual or health care entity listed above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

OAKWOOD UNIVERSITY

HEALTH AND COUNSELING SERVICES
Cunningham Hall 7000 Adventist Blvd. Huntsville, AL 35896
Phone: 256-726-7840 Fax: 256-726-7471 Email: ouhs@oakwood.edu

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____Student ID#:_____

Previous Name: _____Date of Birth: _____ Phone Number(s): _____

I request and authorize the release of my health information as specified below:

FROM Name: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____ Fax: _____

To Name: Oakwood University Health Services

Address: 7000 Adventist Blvd.

City: Huntsville State: AL Zip Code: 35816

Phone: (256) 726-7840 Fax: (256) 726-7471

This request and authorization apply to:

- ☐ Immunization Records Only _____ Email or Fax ouhs@oakwood.edu or (256) 726-7471
- ☐ Health Care information relating to the following treatment, condition, or dates: _____
- ☐ All health care information
- ☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

Yes___ No ___ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes___ No___ I authorize the release of any records regarding drug, alcohol or mental health treatment to the individual or health care entity listed above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED