AURORA UNIVERSITY

Health Services

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 Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated and signed.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

(Please list last year attended: _____ and Student ID#: _____)

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

_____ Immunization Records

_____ Care delivered on this specific date only ____ / ____ / ____

_____ Other: _____

This information is to be released to: *(Please indicate method of transmission)*

Aurora University
Health Services
347 S. Gladstone Ave.
Aurora, IL 60506
Phone: (630) 844-5434
Fax: (630) 844-5611
Email: shs@aurora.edu

Or to:

_____
Name

_____
Address

_____
City/State/Zip

_____
Telephone Number

_____
Fax Number

_____
Email Address

**Please note: By signing you recognize that Aurora University is no longer responsible for the safety and handling of release records.

_____ _____
Student's Signature Date

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

Rev. 09/2022