Wellness Center

Health Information Sharing Authorization

Patient Name:____

Date of Birth:______________________

T#:______________________________

I authorize the Wellness Center Health Clinic to share my medical information with the following individual(s):

Name (print):____

Relationship:____

Phone:___________________________

Name (print):____

Relationship:____

Phone:___________________________

I understand that I may remove this authorization ***in writing*** at any time, and that this authorization will expire in 1 (one) year from the date of my signature.

Student Name (print):______________________________________

Student Signature:___________________________________ Date:_______________

Witness Name (print):______________________________________

Witness Signature:____ Date:_______________

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