MICA STUDENT HEALTH
MARYLAND INSTITUTE COLLEGE OF ART
1501 W Mount Royal Ave 2nd Floor
Baltimore MD 21217
Phone:410-225-4118 Fax: 410-225-0252

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization will automatically expire sixty days from the date signed. I understand that I may revoke this authorization at any time by writing to the Director at Maryland Institute College of Art Student Health Center, but it will not affect any information previously sent.

PATIENT INFORMATION (Please Print)

Last Name	First Name	Middle Initial	MICA STUDENT ID #

Street Address	Birth Date

City	State	Zip Code	Phone Number

I REQUEST THAT MICA STUDENT HEALTH CENTER:

(CHECK ONLY ONE)

☐ **RELEASE MY RECORDS TO** ☐ **RECEIVE MY RECORDS FROM**

Name			
Mailing Address			Phone Number
City	State	Zip Code	Fax Number

METHOD (Records cannot be emailed)	☐ PICK UP	☐ MAIL	☐ FAX
	Records must be picked up within 30 days of completion	Please note, after two unsuccessful attempts via mail/fax, you will be contacted to pick up your records within 30 days.	

RECORDS TO INCLUDE	DATE (IF APPLICABLE)	**DO NOT INCLUDE**	DATE (IF APPLICABLE)
☐ Full Medical Record **OR**		☐ HIV Related Information	
☐ History & Physical Exam		☐ STI/ Communicable Disease Related Information	
☐ Sexual Health/ GYN Records		☐ Alcohol/Drug Abuse Related Information	
☐ Immunizations/ PPD		☐ Mental Health Diagnosis/ Treatment Information	
☐ Laboratory Tests/ Radiology			
☐ Other: _____			

PURPOSE OF DISCLOSURE OF INFORMATION	☐ At Patient's Request ☐ School/ Employment ☐ Continuity of Care ☐ Other: _____

I understand that the MICA Health Center may not condition its provision of treatment on my signing this authorization, with the following two exceptions:

1. If I refuse to authorize disclosure for research purposes, MICA Health Center may refuse to provide treatment related to that research.
2. If I refuse to authorize disclosure to a third party, MICA Health Center may refuse to provide health care that is solely for the purpose of disclosure to that third party (e.g., physical exam to Nursing or Athletic Department).

I understand that I may revoke this authorization at any time, by writing to the Director at MICA Student Health Center. The revocation will become effective on the day the University receives it, except to the extent that: (a) the University has made a disclosure before the effective date of the revocation; or (b) if the authorization was obtained as a condition of obtaining health insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Charges may apply for requested records.

METHOD OF NOTIFICATION	☐ Records Given to Patient at Time of Request ☐ Email Confirmation of Request Completion to: _____ @ _____. _____

PLEASE NOTE: ALLOW 3-5 BUSINESS DAYS FOR COMPLETION OF REQUEST

Signature	Date

OFFICE USE ONLY

Received in office by: _____ Date: _____	Completed by: _____ Date: _____

Pick up verification: ☐ Not Applicable
Staff Member: _____ Date: _____

ID Type: ☐ OneCard ☐ License/ Government ID ☐ Other: _____

Pick up signature: _____