

**PARENTAL/GUARDIAN CONSENT
TO RELEASE MEDICAL INFORMATION**

In accordance with regulations contained within the **Family Education Rights and Privacy Act (FERPA)**, Alvernia University Health and Wellness Center will maintain all student medical information as Treatment Records, separate from students' Education Records. Information from a student's Treatment Record will only be disclosed to designated parties with the written consent of the student, *with the exception of a health or safety emergency.*

I hereby consent to the disclosure of the information contained in my Treatment Record to the individuals listed below, for reasons determined by Alvernia University Health and Wellness Center as appropriate.

I hereby consent to authorize the Alvernia University Health and Wellness Center to discuss my health information with the following people:

Emergency Contact	Relationship	Phone Number
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Additional Contact	Relationship	Phone Number
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Date: _____

Signature: _____

Printed name: _____

My authorization may be revoked at any time by completing the portion in the box below.

Please do not complete this portion until you would like to revoke authorization:

On this date, I would like to revoke the above authorization and discontinue the release of information to those identified above.

Date: _____

Signature: _____

Printed name: _____