# SP HEALTH CLINIC

Authorization to Release Medical Information

**Please print your information clearly below:**

## PATIENT INFORMATION

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email:_____

## AUTHORIZED LIST OF PERSON(S)

*If you have any additional person(s) to list, please use the back of this form to list them. If you DO NOT authorize anyone else but yourself, you may leave this section blank.*

Full Name:_____

Phone:_____ Relationship:_____

Full Name:_____

Phone:_____ Relationship:_____

Full Name:_____

Phone:_____ Relationship:_____

**Signature:**_____ Date:_____

*By signing above you agree to have the named person(s) on this form have access to retrieve your medical records, this includes lab results, radiology, doctor's note, and date of visit(s). You have the right to revoke anyone on this form at any time. To make changes, please email us at studenthealth@spclinic.org or call us directly.*

***COVID Results:** It is important to understand that any COVID results can be shared with Hawaii Pacific University to allow for proper tracking and quarantine restrictions that may need to be placed for the safety of other students and staff on campus.*