Lincoln University
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LINCOLN UNIVERSITY HEALTH SERVICES
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR PATIENT INFORMATION

1570 Baltimore Pike
Wellness Center
Lincoln University, PA 19352
(484) 365-7338 (voice) **(484) 365-7287 (fax)**

Date of Request: ____________________

Patient's Name: ____ (Please Print Legibly)

Date of Birth: ______________________ Social Security Number: _____________________

Contact Number:____

Authorized Signature: ____

Please Check One:

_____ This authorization is a request for records to be sent **TO** Lincoln University

In accordance with the Federal Health Insurance Portability and Accountability Act of 1996, I hereby authorize ____ to release the following records and/or information to the Health Services Office at Lincoln University. Please fax them to 484-365-7287 or email to healthservices@lincoln.edu.
____
____

_____ This authorization is a request for records to be **sent FROM** Lincoln University

In accordance with the Federal Health Insurance Portability and Accountability Act of 1996, I hereby authorize Health Services to release to____
the following records and/or information: ____
____
____

Fax number you would like us to send your records to: _______________________ATTN:___________________

****Please allow 7-10 business days for your request to be processed****

Revised: 2018