Lincoln University
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR PATIENT INFORMATION

Office of Health Services
1570 Baltimore Pike
Wellness Center Suite 100
Lincoln University, PA 19352
(484) 365-7338 (voice) **(866)563-6196 (fax)**

Date of Request: _____

Patient's Name: _____ (Please Print)

Date of Birth: _____ Student ID number: _____

Phone Number: _____

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 1-866-563-6196 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 the following records and/or information:
_____
_____
_____
To the person(s)/facility listed: _____

Fax number you would like us to send your records to: _____ATTN:_____

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