Authorization for Disclosure of Health Information

By completing the form below, you grant permission to the AUD Health Center to disclose, or not, your son's or daughter's medical records. You have the right to revoke this consent at any time by notifying the AUD Health Center in writing.

Name: ----------
Relation: ----------
Telephone (Mobile): ----------
Email: ----------

Student Name: ----------
AUD ID Number: ----------
Address----------
Telephone (Mobile): ----------
Date of Birth: ----------
Gender: F M

☐ I authorize the AUD Health Center to disclose information contained in my son's/daughter's medical records

☐ I do not authorize AUD Health Center to disclose information contained in my son's/daughter's medical records

Date: ----------
Parent's Signature: ----------

In order to clear your son's or daughter's health status, kindly scan the endorsed completed form, and upload for verification.

All health information is confidential. Disclosure by the Health Center is on an as-needed basis.