Authorization for Disclosure of Health Information, Parents

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 University Health Center in writing.

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

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

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

2. 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, upload and attach to the PCR Test result application for verification.

All health information is confidential. Disclosure by the Health Center is on an as-needed basis (only for the implementing accommodations).